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PATIENT REGISTRATION FORM **DX Code(s):** _____

(Please complete all areas of form and provide a copy of your insurance card(s)

PATIENT INFORMATION

Patient Name: _____ **Sex: M [ ] F [ ]**

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Email:** _____

Home: (_____)_____ Work: (_____)_____ Cell: ( ) _____

OK to leave a message at: HOME Yes [ ] No [ ] WORK YES [ ] NO [ ] CELL YES [ ] NO [ ]

SS#: _____ **Date of Birth:** _____ **Employer:** _____

Occupation: _____ **Name of Spouse/Partner:** _____

Emergency Contact: _____ **Phone#:** _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE PATIENT): _____

Responsible Party Billing Address/City/Zip Code: _____

Relationship _____ **Contact #:** _____ **SS#:** _____

PRIMARY INSURANCE

Primary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

SECONDAY INSURANCE

Secondary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN

I was referred by: _____ **PCP/Phone#:** _____

I, _____, have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout. I am also responsible to pay for all missed appointments and late cancellations.

Patient and/or Guardian Signature: _____ **Date:** _____