

Patient Registration

Name _____ SS# _____ DOB: _____

Marital Status: **S** **M** **W** **Sep.** Spouse's name _____

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone _____

Referred by: _____

E-mail Address _____

Patient Employer Information

Employer Name _____ Phone number _____

Street Address _____ City/State _____ Zip _____

Patient's occupation _____

Emergency Contact

Name _____ Tel# _____ Relationship _____

Insurance Information

Insurance Company Name _____ ID# _____

Primary Policy Holder _____ DOB: _____ Relationship _____

Medical Information Release and Assignment of Benefits

I hereby assign my insurance benefits to be made directly to the doctor and/or his/her associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payments, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original

I hereby acknowledge that I have read, understand and agree to hereby give consent to assess, treat and test.

Signature _____ Date _____