

**PATIENT REGISTRATION FORM**



Today's Date: \_\_\_\_\_

**PATIENT INFORMATION: (Please use full legal name)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**PRIMARY INSURANCE / GUARANTOR INFORMATION: (List person or insured name responsible for account - use full legal name)**

Relationship of Guarantor to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: (if different from patient) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents covered under this plan: \_\_\_\_\_

**ADDITIONAL INSURANCE:**

Is Patient Covered by Additional Insurance: Y \_\_\_\_\_ N \_\_\_\_\_

Plan Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Claims Address: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I certify that I, and/or my dependents(s) have insurance coverage with \_\_\_\_\_ and assign  
Name of insurance company(ies)

directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance companies(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Representative

\_\_\_\_\_  
Date Relationship to Patient