PATIENT REGISTRATION FORM

PLEASE PRINT

NAME _____
LAST FIRST MIDDLE INITIAL

STREET_____

CITY_____ STATE_____ ZIP CODE_____

REFERRING DOCTOR /PCP _____ PHONE # _____

HOME PHONE _____ WORK PHONE_____ CELL_____

BIRTH DATE_____ Gender: M____ F____ Other_____

MARTIAL STATUS: MARRIED_____ SINGLE_____

EMAIL: _____

PRIMARY INSURANCE COMPANY_____

POLICY #_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED? SELF_____ SPOUSE_____ CHILD_____ OTHER_____

SUBSCRIBER NAME, IF NOT THE SAME_____DATE OF BIRTH_____

SECONDARY INSURANCE COMPANY_____

POLICY # _____ GROUP # _____

VERIFICATION OF BENEFITS INFORMATION

Number of visits covered: _____ Deductible information: in network deductible?_____

Preventive Benefit: _____ Representative name: _____

Date of verification of coverage_____ __ Reference # for call_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR IT INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PROVIDER, ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICAL CLAIM. I PERMIT A COPY OF EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

IF YOUR INSURANCE COMPANY FAILS TO PAY FOR SERVICES, YOU WILL BE RESPONSIBLE FOR PAYMENT. NOTE: IF NOT GIVING 24 HOURS NOTICE OF CANCELLATION OF AN APPOINTMENT, YOU WILL BE CHARGED A FEE OF $75.00.

SIGNED_____ DATE_____