

(Please print clearly)

Patient Registration Form

Patient Information

Name (First, Middle, Last): _____

Date of Birth: _____ Social Security Number: _____ Sex: Male Female

Local Mailing Address: _____ Patient Email Address: _____

City / State / Zip code: _____ **(Email Addresses will be kept CONFIDENTIAL)**

Local Phone Number: _____ Other Phone Number: _____

Primary Care (Last name, first): _____ Referring Physician: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

How did you find out about our practice? _____

Insurance Information (Guarantor, Parent, or other Responsible Party)

Primary Insurance: _____ Group #: _____ ID #: _____

Secondary Insurance: _____ Group #: _____ ID #: _____

☞ Only complete the next four lines if the information is different from above

Name (First, Middle, Last): _____ Relationship to patient: _____

Date of Birth (Month/Day/Year): _____ Social Security Number: _____

Local Address: _____

Local Phone Number: _____ Other Phone Number: _____

Authorization and Payment Terms

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to avoid any misunderstanding regarding our payment policies, please ask for a copy of our Financial Policy if you have not received one. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of service.

➤ We accept payment via cash, check, debit cards, Master Card, Visa, Discover or American Express.

Your signature below authorizes the release of your medical information and payment as listed above, and signifies your willingness to comply with our financial policy (attached). Please present your insurance card(s) and a photo ID to the receptionist. These will be copied and placed in your medical record for identification purposes and for protection of your Private Health Information.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient). In the event that a spouse, family member, or close friend may need this information, please list their name in the space provided below.

Name: _____ Relationship: _____

By listing the individual above, you have given us permission to discuss your medical history and treatment with this person. We cannot disclose any of your private health information to anyone who is not listed on this form.

Patient or Responsible Party Signature: _____ Date: _____