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PATIENT REGISTRATION

Patient Information:

Patient Name _____
(First) (M.I.) (Last)

Mailing Address _____
(Street) (City) (State) (Zip)

Home Phone() _____ Cell Phone() _____ Email _____

Birthdate: _____ Sex(circle one): M F T Marital Status(circle one): M S D W P SSN: _____

Employer _____ Address _____ Work Phone() _____

Primary Care Provider _____ Referring Provider _____

Emergency Contact _____ Phone() _____ Relationship _____

Responsible Party/Billing Information: (complete only if different from above)

Name _____
(First) (M.I.) (Last)

Mailing Address _____
(Street) (City) (State) (Zip)

Home Phone() _____ Cell Phone() _____ Birthdate: _____

Employer _____ Address _____ Work Phone() _____

Insurance Information: (bring cards to appointment)

Primary Insurance _____ Policy# _____ Group# _____

Name of Insured _____ Relationship to Patient _____ DOB _____

Secondary Insurance _____ Policy# _____ Group# _____

Name of Insured _____ Relationship to Patient _____ DOB _____

Worker's Compensation:

WC Company _____ Employer _____ Phone() _____

Mailing Address _____
(Street) (City) (State) (Zip)

Accident Claim# _____ Date of Injury _____ Date Last Worked _____

ASSIGNMENT AND RELEASE: I HEARBY AUTHORIZE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE INFORMATION REQUIRED.

Patient/Responsible Party Signature: _____ Date: _____