Date _____ (PLEASE PRINT) Home Phone ____ _____

Patient Information

Name _____ _____ _____ SS/HIC/Patient ID # _____

Last Name First Name Middle Initial Cell Phone ____ _____

City _____ State _____ Zip _____

Sex M ◯ F ◯ Age ____ Birth Date _____ Married ◯ Widowed ◯ Single ◯ Minor ◯

Seperated ◯ Divorced ◯ Partnered for ◯ ____ Years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone ____ _____

Who may we thank for refering you? _____

In case of emergency who sholud be notified? _____ Phone ____ _____

Primary Insurance

Person responsible for this account _____ _____ _____

Last Name First Name Middle Initial

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone ____ _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone ____ _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this paln _____

Additional Insurance

Is patient covered by additional insurance? Yes ◯ No ◯

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address _____ Phone ____ _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Phone ____ _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this paln _____

Assignment and Release

I certify that I, and/or my dependent(s),have insurance coverage with _____ and

Name of Insurance Company(ies)

assign 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 Comany(ies) and their agents for the purpose of obtaining payment for services and determing 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 Date

_____ _____

Please print name ofPatient,Parent,Guardian or Personal Representative Relationship to Patient

Registration Form