

Patient Registration

Who Referred You? How Did You Hear About Us? *(please select and specify all that apply)*

- Physician*
- Self-referred
- Internet/Web Site
- Insurance Directory
- Friend/Other Patient

- Television _____
- Radio _____
- Magazine _____
- Newspaper _____
- Other _____

*Physician Name _____
 Street Address _____
 City _____ Phone _____
 Specialty _____

Patient				Partner			
Name (Last, First, Middle Initial)				Name (Last, First, Middle Initial)			
Address				Address			
City/State/Zip				City/State/Zip			
Social Security No.		Cell Phone		Social Security No.		Cell Phone	
Home Phone		Work Phone		Home Phone		Work Phone	
Personal Email		Date of Birth - Age		Personal Email		Date of Birth - Age	
Marital Status		Marriage Date		Marital Status		Marriage Date	
Patient's Employment				Partner's Employment			
Company Name		Occupation		Company Name		Occupation	
Address				Address			
City/State/Zip				City/State/Zip			
Patient's Primary Insurance				Partner's Primary Insurance			
Insurance Company Name				Insurance Company Name			
Address				Address			
City/State/Zip				City/State/Zip			
Phone				Phone			
Policy Holder Name				Policy Holder Name			
Policy No.		Group No.		Policy No.		Group No.	
Emergency Contact							
Name		Day Phone		Night Phone		Relationship	
Authorizations							
<p>AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay no-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s). I will pay you all costs of collection, including attorney's fees, up to the maximum permitted under applicable law, and other charges, if incurred.</p> <p>AUTHORIZATION TO RELEASE INFORMATION: I Hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.</p>							
Patient				Partner			
Signed (Patient or Parent if Minor)		Date		Signed (Patient or Parent if Minor)		Date	