Patient Registration Form

Patient Information:

Name: ____________________ Age: ________ DOB: ____________ Male/Female (circle)

Address: ____________________ City, State, Zip: ____________________

Primary phone: **Email** ____________________ Secondary Phone: ____________________

Address: ____________________ Preferred method of contact: Text/Call/Email Other

****Referring physician:** ____________________ Physician: ____________________

Primary Insurance:

Name of Insurance: ____

Policy #: ____________________ Group # ____________________

Policy Holder Name: ____________________ DOB: ____________________

SSN#: ____________________ Phone: ____________________

Secondary Insurance:

Name of Insurance: ____

Policy #: ____________________ Group # ____________________

Policy Holder Name: ____________________ DOB: ____________________

SSN#: ____________________ Phone: ____________________

Responsible party:

Name: ____________________ DOB: ________ SSN#: ____________________

Relation to patient: parent ________ Guardian ________ Self ________ Other ________

Address: ____________________ City, State, Zip: ____________________

Primary phone: ____________________ Secondary Phone: ____________________

Employer: ____________________ Work phone: ____________________

Employer address: ____________________ City, State, Zip: ____________________

Authorized signature is on file. By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that: 1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice; 2). I am fully responsible for all charges to me including the balance remaining after payment of insurance benefits (as per your insurance contract); 3) a $25.00 fee will be charged on each returned check; 4) payment is expected on the day services are rendered unless prior arrangements are made; and 6) the information in this paragraph may not be altered or amended by me.

All co-pays are due at the time of service or no services will be rendered.

Patient/Responsible Party Signature: ____ Date: ______________