PATIENT REGISTRATION

Please fill out completely
Name (Last) _____ (First)_____ (MI) _____
Address _____
Street City State Zip
Home Phone _____ Cell Phone _____ E-Mail _____
Sex _____ DOB _____ Age ____ SSN _____ Marital Status _____
Employer _____ Phone _____
Primary Care Physician _____ Address_____ Phone #:_____
Doctors Referral (Name & Phone of Referring Physician):_____

Is this a work related injury or illness? Y / N
Is this an injury or illness related to an auto accident? Y / N

Financial Guarantor Information (Policy holder or person other than patient guaranteeing payment)
Name (Last) _____ (First) _____ (MI) _____
Street Address _____
City State Zip
Home Phone _____ Cell Phone _____ E-Mail _____
DOB _____ Age _____ SSN _____ Relationship to Patient _____
Employer _____ Phone _____

Emergency Contact (Close friend or relative that we can contact in an emergency)
Name _____ Phone _____ Relationship _____

Primary Insurance Information
Insurance _____ Member/Policy # _____Group #_____
Policy Holder's Name _____ Employer _____ Phone _____

Secondary Insurance Information
Insurance _____ ___ Member/Policy # _____Group #_____
Policy Holder's Name _____ Employer _____ Phone _____

Self pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

I request that payment of authorized insurance and Medicare benefits be made payable to the above practice on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason.

I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize the practice to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

I have been made aware of the privacy policies of the practice and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENT OR GUARANTOR _____DATE _____