

# REGISTRATION FORM

	PHYSICIAN NAME	OFFICE NAME/LOCATION			
2 - PATIENT INFORMATION	Patient First Name	M.I.	Last Name		
	Patient Address		Cell Telephone Number ( )		
	City	State	Zip	Home Phone ( )	
	Emergency Contact Name	Emergency Phone ( )	Emergency Contact Relationship		
	Patient Date of Birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D	Patient SS#	
	Patient Employer Name	Employer Address		Employer Phone ( )	
1 - BILLING INFORMATION	Bill to / First Name	M.I.	Last Name		
	Billing Address	City	State	Zip	Home Phone ( )
	Guarantor SS#	Guarantor Date of Birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D	
	Guarantor Employer Name	Guarantor Employer Address		Guarantor Work Phone ( )	
	Spouse's Name	Spouse's Employer Name & Address		Spouse's Work Phone ( )	
3 - PRIMARY INSURANCE	Primary Insurance Eff. Date	Primary Ins. Name	Primary Ins. Address		
	Ins. Phone	Group Number	Policy Number	Patient Relationship to Insured <input type="checkbox"/> 1- Self <input type="checkbox"/> 2-Spouse <input type="checkbox"/> 3-Child <input type="checkbox"/> Other	
	Insured's Name	Insured's Address	City/State/Zip	Phone ( )	
	Insured's Date of Birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Insured's SS#		
	Insured's Employer Name	Insured's Employer Address		Insured's Work Phone ( )	
4 - SECONDARY INSURANCE	Secondary Insurance Eff. Date	Secondary Ins. Name	Secondary Ins. Address		
	Ins. Phone	Group Number	Policy Number	Patient Relationship to Insured <input type="checkbox"/> 1- Self <input type="checkbox"/> 2-Spouse <input type="checkbox"/> 3-Child <input type="checkbox"/> Other	
	Insured's Name	Insured's Address	City/State/Zip	Phone ( )	
	Insured's Date of Birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Insured's SS#		
	Insured's Employer Name	Insured's Employer Address		Insured's Work Phone ( )	
Do you have any other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Please give completed form and all insurance cards to receptionist.					
5 - AUTHORIZATION / RELEASE	<p>I authorize physician/physician group above to provide treatment and or tests to me. In signing this agreement, I certify that the above stated facts are correct. I/we hereby assign and authorize payment of all insurance benefits directly to the physician/physician group above. I/we hereby authorize the physician/physician group above to furnish information from the patient's medical records to insurers, compensation carriers, healthcare facilities, or other agencies which may be providing financial assistance for the patient's care. I understand that I am financially responsible for any balance not covered by insurance and any collection agency fees.</p>				
	_____ / _____ / _____ Date	X _____ Signature of Insured or Authorized Person			
FOR OFFICE USE ONLY <input type="checkbox"/> Registration form verified for complete/accurate information <input type="checkbox"/> Copy of insurance card(s) obtained (front & back) <input type="checkbox"/> Copay amount _____ <input type="checkbox"/> Copay entered into system					