Patient Registration

Patient's Name_____ **Today's Date**_____

Home Address_____

City_____ **State**_____ **Zip code**_____

Telephone (___)_____ **Birth Date**_____ **SS#** _____

Email Address_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Employer_____

Employer's Address_____

City_____ **State**_____**Zip code**_____

Employer's Telephone (___)_____

Name of Husband/Wife or Guardian_____

Birth Date_____ **SS #**_____

Employer_____

Employer's Telephone (___)_____

Referring and/or Primary Care Physician _____

Emergency Contact (Not a relative & not living with you):

_____ **Relationship**_____

Home Phone (___)_____ **Work Phone (___)**_____

Primary Insurance Company_____

Secondary Insurance Company_____

1. **Our office will file insurance for your charges. You will need to pay any applicable co-pays and deductibles at the time of service. Please remember that you are responsible for all fees, regardless of insurance coverage.**
2. **I understand that I am responsible for obtaining a referral from my primary care physician as stipulated by MY particular policy/plan.**
3. **I authorize the release of any medical information necessary to process this claim.**
4. **I authorize the release of medical and surgical benefits.**

_____ _____

Signature Date