



Initial Appt Date: _____
Time: _____

PATIENT REGISTRATION
Please fill out this form completely.

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Evening: () _____ Day Phone: () _____ Cell: () _____

Date of Birth: _____ Soc Sec# _____ Age: _____ Sex _____ Ht: _____ Wt: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Race: ___ White ___ African American ___ Asian American ___ American Indian ___ Alaska Native ___ Pacific Islander ___ Choose to not answer

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City _____ St _____

Zip _____ Employer Phone: _____

Primary Care Physician: _____ Phone# _____ Fax _____

HOW DID YOU HEAR ABOUT US?

TV (which program): _____

Doctor: _____

Radio (which station): _____

Internet: _____ which website/search engine: _____

Newspaper (which one) _____

Newspaper (which one): _____

Billboard: _____ Word of Mouth: _____ Friend: _____

Patient: _____

Self-Pay or Financed Patient _____

INSURANCE INFORMATION

Primary Insurance: ___ Medicare ___ Medicaid ___ HMO ___ PPO ___ POS ___ OTHER

Primary Card Holder's Name _____ Primary Card Holder's Soc Sec#: _____

Relationship to patient: _____ Insurance Name: _____ Phone: _____

Policy # _____ Group # _____ ID# _____

Claims Address: _____

Secondary Insurance: ___ Medicare ___ Medicaid ___ HMO ___ PPO ___ POS ___ OTHER

Primary Card Holder's Name _____ Primary Card Holder's Soc Sec#: _____

Relationship to patient: _____ Insurance Name: _____ Phone: _____

Policy # _____ Group # _____ ID# _____

Claims Address: _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone number: _____

Would it be best to contact you by ___ phone or ___ email? If by phone when is the best time of day to reach you (between 9:00 am and 5:00 pm)? _____ At what number? _____ A specific day of the week? _____

I, the undersigned, certify that the above information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare or Insurance carrier on my behalf.

Patient Signature _____ Date: _____