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Patient Registration Form

PATIENT INFORMATION: (Must Complete)

Patient Name _____ Date _____
Last First Middle

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Address _____
Street City, State Zip

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ email _____

Marital Status: Single Married Widowed Divorced Separated Minor Child

If patient is a minor, lives with _____ Relationship _____

Patient or Parent

Employed Occupation _____ Retired Full-time Student Part-time Student

Employer and/or School Name and Address _____

Spouse's Name _____ Social Security # _____ Birthdate _____

Spouse's Employer _____ Phone # _____

Employer Address _____

Primary Insurance Holder / Responsible Party: If Other than the Patient, Please Complete

Name _____ Relationship to Patient _____

Address, if other than same _____

Home Phone (____) _____ Work Phone (____) _____ Social Security # _____

Responsible Party's Birthdate _____ Employer Name & Address _____

Emergency Contact. Nearest Friend/Relative Not Living With You

Name _____ Relationship to Patient _____

Address (If other than same) _____ Phone (____) _____

Referring Physician / Medical Insurance Information

Name of Referring Physician _____ Phone # _____

Name of Family or Primary Care Physician _____ Phone # _____

Physician Address _____

Do you have medical insurance to cover your examination or treatment? Yes No

If Yes, we will take a copy of your insurance cards. If you do not have an insurance card, please indicate ins. carrier name and your I.D. # _____

Does your insurance company require a formal authorization or referral for exam or treatment from a Primary Care Physician? Yes No If Yes, Physician's name _____

Accident Information. Complete if your treatment is for an injury or accident.

Were you injured at work? Yes No Is this covered by Workman's Compensation? _____

If Yes, Contact person at your Employer _____

Date & time of Accident _____ Place of Accident _____

How did injury happen? _____

Name of Physician who treated you at time of accident _____

Financial Responsibility Statement / Release of Information Authorization

I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Physician for services received. I also authorize the release of information to the listed physicians and/or individuals. I understand that this authorization remains valid unless / until I revoke it myself.

X _____ Date _____
Signature of Patient or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.

X _____ Date _____
Signature of Patient or Legal Guardian

Photography Release

I consent that photographs may be taken in connection with the medical services I receive. I understand that such photographs shall be used in my medical record and may be shared with others, including but not limited to, my insurance carrier. I also give permission for these photographs and information relative to them and/or relating to my case to be published and republished for the purposes of medical research, education or science; and I specify that any such publication of these photographs will not include my name. I understand that this release remains valid unless / until I revoke it myself.

X _____ Date _____
Signature of Patient or Legal Guardian