Patient Registration

Name:_____ Birthdate:_____
First Middle Initial Last

Address:_____ Apt. #:_____

_____ Zip:_____
City State

Marital Status: ☐ Married ☐ Single ☐ Other_____ Sex ☐ M ☐ F

Home Phone Number:_____ Cell Phone:_____

Social Security Number:_____

Employed by:_____ Work Phone Number:_____

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

Name of physician who referred you (if applicable):_____

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST

In case of an emergency, please contact: Name:_____

Relationship:_____ Alternate Phone:_____

Do we have permission to:

Leave a message on your answering machine at home or on cell?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss your medical condition with family member?	☐ Yes	☐ No

If yes, please give name:_____ Relationship to you:_____

Payment is due at the time service is rendered for co-pays, deductibles, co-insurance amounts and any other services or treatment not reimbursed by your insurance. Cancellations with less than 24 hours notice are subject to a $50.00 charge. Returned checks will incur a $30.00 fee. Accounts with balances owing after insurance determination, are due in full within 30 days of our statement to avoid a $25.00 rebilling fee.

This office has provided its Notice of Privacy Practices for me to review.

My signature authorizes this office to release information for treatment, payment and health care operations and certifies that I have read and understand the financial policies of this office.

_____ Date:_____
Signature of patient or legal guardian