



REGISTRATION

(PLEASE PRINT)

Date _____ Home /Cell Phone _____

Patient _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed By _____

Business Address _____ Business Phone _____

Occupation _____ Degree _____

Spouse (or responsible party) Name _____ Birthdate _____

Social Security# _____

Business Name and Address _____

Occupation _____ Business Phone _____

Do you have Medical Insurance? No Yes If yes,

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____ Phone _____

How did you learn of our practice? _____

Payment/insurance Agreement & Authorization to Send Reimbursement Information

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my copayment and/or deductibles are expected at the time services are rendered. I understand that, as a courtesy, the doctor will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the doctor release information to the collection agency, attorneys, and/or the courts. In addition, if I have requested that the doctor file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor provide confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor to provide additional information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature of adult patient or parent/legal guardian of patient less than 18 years of age

Date

For Doctor use : _____