Registration Form

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Date_____ DX Code_____

Patient Information

Patient Name (Print)_____ Date of Birth_____
Last Name First Name Initial

Street Address_____ Cell Phone { }_____

City_____ State_____ ZIP_____ { }_____

Email_____ Emergency Contact_____ Emerg Phone { }_____

Sex: ☐ Female ☐ Male Age_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Employer_____ Occupation_____

Referred by_____ May we acknowledge this referral?_____

Primary Insurance

Primary Insurance Company_____ Phone { }_____

Ins Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
last name First name Middle Initial

Address_____ City_____ State_____ Zip_____ Date of Birth_____

Email_____ Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone { sdsd }_____

Ins Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
last name First name Middle Initial

Address_____ City_____ State_____ Zip_____ Date of Birth_____

Email_____ Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name_____ Relationship _____

Address_____ Phone { }_____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date