

Registration Form

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Date _____

DX Code _____

Patient Information

Patient Name (Print) _____ Date of Birth _____
Street Address _____ Last Name _____ First Name _____ Initial _____ Home Phone { } _____
City _____ State _____ ZIP _____ Work Phone { } _____
Email _____ Emergency Contact _____ Emergency 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 { } _____
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