



PATIENT REGISTRATION FORM

PATIENT	Name <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				Phone
	Address				Work Phone
	City		State	Zip	County
	DOB	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Social Security No.
	Occupation	Employer			Employer Phone
	Employer Address				
RESPONSIBLE PARTY	Name <input type="checkbox"/> Same as patient (Go to INSURANCE Section) <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				Phone
	Address				Work Phone
	City		State	Zip	County
	DOB	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Social Security No.
	Occupation	Employer			Employer Phone
	Employer Address				
INSURANCE	Primary Policy Holder	<input type="checkbox"/> Same as Responsible Party	<input type="checkbox"/> Same as patient	DOB	<input type="checkbox"/> Patient is Spouse <input type="checkbox"/> Patient is Child
	Address	<input type="checkbox"/> Same as Responsible Party	<input type="checkbox"/> Same as patient	Employer	
	City	State	Zip	Employer Address	
	Primary Insurance	Plan Number	Group Number	Date of Coverage	Employer Phone
	Secondary Policy Holder	<input type="checkbox"/> Same as Responsible Party	<input type="checkbox"/> Same as patient	DOB	<input type="checkbox"/> Patient is Spouse <input type="checkbox"/> Patient is Child
	Address	<input type="checkbox"/> Same as Responsible Party	<input type="checkbox"/> Same as patient	Employer	
	City	State	Zip	Employer Address	
	Secondary Insurance	Plan Number	Group Number	Date of Coverage	Employer Phone
NEAREST RELATIVE	Emergency Contact				Phone
	Address				Work Phone
	City	State	Zip	Relationship	
	How did you hear of us? <input type="checkbox"/> HMO or PPO list <input type="checkbox"/> Newspaper <input type="checkbox"/> Phone Book <input type="checkbox"/> Brochure <input type="checkbox"/> Friend or Family <input type="checkbox"/> Physician Office <input type="checkbox"/> Other: _____				

Co-payments and charges for services that are not covered by my insurance company are due at time of the office visit. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behalf. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE: _____ DATE: _____