Patient Registration

Patient Name: _____ Social Security # _____
Last First M
Street Address: _____City: _____State: _____Zip _____

Home Ph: _____Work Ph: _____Date of Birth: ____-____-_____Age: ____Sex: ___Marital Status: ___

Referred By: _____

Allergies: _____

(Under 18)
Mother's/Wife Name: _____ Social Security #_____
Last First MI
Street Address: _____City: _____State: _____Zip _____

Home Ph: _____Work Ph: _____ DOB: _____-_____-_____ Age: ____ Marital Status: ____

(Under 18)
Father's/Husband Name: _____ Social Security #_____
Last First MI
Street Address: _____City: _____State: _____Zip _____

Home Ph: _____Work Ph: _____ DOB: _____-_____-_____ Age: ____ Marital Status: ____

Insurance: _____ Phone: _____

Policy Holder's Name: _____ Relationship to Patient: _____ Sex: _____ DOB: _____

Policy Holder's Employer: _____ Employer Phone #: _____

Subscriber ID# _____ Group: _____ Plan #: _____

Secondary Insurance: _____ Phone: _____

Policy Holder's Name: _____ Relationship to Patient: _____ Sex: _____ DOB: _____

Policy Holder's Employer: _____ Employer Phone #: _____

Subscriber ID# _____ Group: _____ Plan #: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

I hereby assign medical benefits due to me to be paid to Infinity Medical Group. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE