REGISTRATION FORM

1. PATIENT INFORMATION

Last Name:______________________________________ First Name:___________________________________MI:___________

Address:____ City:____________________________State:_____ Zip:_____________

Sex (circle): M F Patient SSN:_______-______-_______ Date of Birth (mm/dd/yyyy):________/_________/__________

Home Phone (____)_______-__________Work Phone (_____)_______-__________Cell Phone (_____)_______-______________

In case of emergency call: Name:________________________ Phone (____)_______-__________ Relationship:_______________

2. **Responsible Party (Fill out if patient under age 18)**

Mother/other

Last Name:______________First Name:____________MI:___

Address:____

City:_________________________State:_________Zip________

Home Phone (____)_______-__________

Work Phone (_____)_______-__________

Cell Phone (_____)_______-__________

Relationship to Patient:___________________________________

Father/other

Last Name:______________First Name:____________MI:___

Address:____

City:_________________________State:_________Zip________

Home Phone (____)_______-__________

Work Phone (_____)_______-__________

Cell Phone (_____)_______-__________

Relationship to Patient:___________________________________

3. Patient Employment Information

Employer:____

Employer Address:_____________________________________

City:_________________________State:_________Zip________

4. Referring Physician (*This is the doctor who referred you to our practice)*

Physician Name:____

Practice Name (if any):__________________________________

City:_________________________State:_________Zip________

Phone (_____)_______-__________

Fax: (_____)_______-__________

DO YOU NEED A REFERRAL (Circle): YES NO

INSURANCE INFORMATION

Failure to complete this section may result in an inability to properly bill your insurance carrier. Please provide us with your insurance card at time of appointment

If you have a SECONDARY INSURANCE, you will need to complete the secondary insurance form on the back of this form.

1. **PRIMARY INSURANCE POLICY INFORMATION**:

Carrier:____

Insurance Address:______________________________________

City:_________________________State:_________Zip_______

Policy #:_____________________ Group #:_________________

2. **INSURANCE POLCY HOLDER** *(person whose employer carries the insurance policy).*

Last Name:______________First Name:____________MI:___

Address:____

City:_________________________State:_________Zip________

DOB(mm/dd/yyyy):______/________/_____

SSN:_______-______-_______ Sex (circle): M F

Home Phone (____)_______-__________

Relationship to Patient:___________________________________

3. POLICY HOLDER'S EMPLOYMENT

Employer:____

Employer Address:______________________________________

City:_________________________State:_________Zip________

PRIMARY CARE PHYSICIAN (*If same as referring physician, check this box* ❑

Physician Name:____

Practice Name (if any):__________________________________

City:_________________________State:_________Zip________

Phone (_____)_______-__________

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Guardian:____ Date:_________/________/_________

REGISTRATION

SECONDARY INSURANCE INFORMATION

Failure to complete this section may result in an inability to properly bill your insurance carrier. Please provide us with your insurance card at time of appointment

1. SECONDARY INSURANCE POLICY INFORMATION:

Carrier:____
Insurance Address:____
City:______________________________________State:_________Zip_______
Policy #:_____________________________ Group #:_____________________________

2. INSURANCE POLCY HOLDER *(This is the person whose employer carries the insurance policy).*

Last Name:_____________________________First Name:_____________________MI:___
Address:____
City:______________________________________State:_________Zip________
POLICY HOLDER DOB(mm/dd/yyyy):______/________/_____
SSN:_______-______-_______ Sex (circle): M F
Home Phone (____)_______-__________
Relationship to Patient:_____________________________

3. POLICY HOLDER'S EMPLOYMENT

Employer:____
Employer Address:____
City:______________________________________State:_________Zip________

TREATMENT

CONSENT FOR TREATMENT:

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Signed:____Date:______________
Patient

Signed:____Date:______________
Patient or Parent/Legal Guardian