PATIENT REGISTRATION

DATE ______________________

FOR INTERNAL USE ONLY
PATIENT NUMBER ______________

PATIENT INFORMATION

FIRST NAME ______________ MIDDLE ________ LAST NAME ______________________

HOME ADDRESS ______________________ CITY ______________ STATE ______ ZIP ______

SEX __________ DATE OF BIRTH ____/____/____ EMAIL ______________________

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

Preferred Method of Contact:

☐ HOME PHONE (_____) ______________

☐ WORK PHONE (_____) ______________

☐ CELL PHONE (_____) ______________

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER ______________________

EMPLOYER ____

PREFERRED PHARMACY ______________________ PHARMACY PHONE (_____) ______________

LANGUAGE: ☐ ENGLISH: ☐ SPANISH: ☐ OTHER: ______________

ETHNICITY: ______________ RACE: ______________ REFERRING PHYSICIAN: ______________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY ____

POLICY ID# ______________________ GROUP# ______________________

INSURED CARD HOLDER'S NAME ______________________ RELATIONSHIP ______________

ADDRESS ______________ PHONE (_____) ______________ DATE OF BIRTH ______________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ____

POLICY ID# ______________________ GROUP# ______________________

INSURED CARD HOLDER'S NAME ______________________ RELATIONSHIP ______________

ADDRESS ______________ PHONE (_____) ______________ DATE OF BIRTH ______________

EMERGENCY CONTACT

FULL NAME ______________________ HOME PHONE (_____) ______________

ADDRESS ______________________ WORK PHONE (_____) ______________

CITY ______________ STATE ______ ZIP ______ CELL PHONE (_____) ______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE ______________________ DATE ______________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize payment directly to the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE ______________________ DATE ______________