PATIENT REGISTERATION FORM

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CELL: _____

_____ HOME: _____

_____ Preferred Pharmacy: _____

CITY ST ZIP

May we leave messages on these numbers? ___ Yes ___ No Which number is best? ___ Cell ___ Home ___Other

☐ MALE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

☐ FEMALE ☐ SINGLE ☐ SEPARATED ☐ SIGNIFICANT OTHER

DOB: _____ Emergency Contact: _____

SSN: _____ Phone Number: _____

Email: _____ Relationship: _____

INSURANCE INFORMATION

Insurance Provider: _____ **PERSON RESPONSIBLE FOR BILL**

Subscriber Name: _____ (IF NOT PATIENT)

Subscriber DOB: _____ Name: _____

I.D. Number: _____ Address: _____

Insurance Group: _____ _____

Relationship to Subscriber: ___ Self ___ Spouse ___ Child ___ Dependent ___ Other

PHYSICIAN INFORMATION

Referring Physician: _____ Primary Physician: _____

Phone: _____ Phone: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to disclose my health care information to insurance companies and their agents for the purpose of obtaining payment for service.

PATIENT SIGNATURE: _____ **DATE / TIME:** _____