Patient RegistrationForm

Please print

for scanning purposes we request that you use only black ink

PATIENT INFORMATION

Last Name:________________________________
First Name:____________________ Middle Initial:___
Address1:_________________________________
Address2:_________________________________
City:____________________________ State: ____
Zip Code:______________________Country:______

Referring Physician:__________________________
Primary Care Physician:________________________

Preferred Language:__________________________

Contact Information: May we leave a detailed message on your answering machine? YES NO

Preferred Telephone # (____) ____-_______ home cell work
Secondary Telephone#(____) ____-_______ home cell work
Third Telephone # (____) ____-_______ home cell work
Gender: male female
Birthdate: ____ / ____ / _______
Email Address:___________________________________

Physician Telephone # (____) ____-_______
Physician Telephone # (____) ____-_______

Race: White American Indian Asian
Black or African American Native Hawaiian Other

Ethnic Group:
Hispanic or Latino Not Hispanic or Latino Decline

**For your protection, and in compliance with Federal Regulatory Requirements to safeguard against identity theft you will be required to provide us with a valid photo ID with your current address and your insurance card every visit. We will scan this into our system in order to verify your identity in respect to any requests for your medical information and submitting of information to your insurance carrier for payment.

ACCOUNT INFORMATON

Is the patient listed above over the age of 18? Yes No

IF YES – patient is responsible for all financial obligations

Last Name:________________________________
First Name:___________________Middle Initial:____
Address1:_________________________________
Address2:_________________________________
City:____________________________State:____
Zip Code:____________________Country:________

IF NO – please provide billing information below

Preferred Telephone # (____) ____-_______ home cell work
Secondary Telephone#(____) ____-_______ home cell work
Third Telephone # (____) ____-_______ home cell work
Gender: male female
Birthdate: ____ / ____ / _______
Relationship to patient: _____________________________

INSURANCE POLICY INFORMATION

Carrier Name:______________________________
Subscriber Last Name:_________________________
Subscriber First Name:____________Middle Initial:____
Address (if different than above) __________________
____

Primary Secondary Tertiary Effective Date of Policy:______
Gender: male female
Birthdate: ____ / ____ / _______
Relationship to patient: _____________________________
Employer:______________________________________

ADDITIONAL INSURANCE POLICY INFORMATION

Carrier Name:______________________________
Subscriber Last Name:_________________________
Subscriber First Name:____________Middle Initial:____
Address (if different than above) __________________
____

Primary Secondary Tertiary Effective Date of Policy:______
Gender: male female
Birthdate: ____ / ____ / _______
Relationship to patient: _____________________________
Employer:______________________________________

ADDITIONAL INSURANCE POLICY INFORMATION

Carrier Name:______________________________
Subscriber Last Name:_________________________
Subscriber First Name:____________Middle Initial:____
Address (if different than above) __________________
____

Primary Secondary Tertiary Effective Date of Policy:______
Gender: male female
Birthdate: ____ / ____ / _______
Relationship to patient: _____________________________
Employer:______________________________________

I understand the provider's charge may exceed the insurance payments, and if greater than such payment. I will be responsible for that amount. Should my account ever become delinquent and eligible for collection, I understand an appropriate collection fee will be assessed.

Signed ____ DATE ____ / ____ / _________