Patient Registration

Welcome to our Practice

PLEASE FILL OUT COMPLETELY, THANK YOU!			
PATIENT NAME			
MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
MALE FEMALE	MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED	MINOR	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
EMPLOYER	DRIVERS LICENSE NUMBER		

PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER THE AGE OF 18 OR IF SOMEONE OTHER THAN YOURSELF IS THE INSURANCE POLICY HOLDER:			PRIMARY INSURANCE INFORMATION	
CHECK ONE: SPOUSE PARENT LEGAL GUARDIAN			INSURANCE COMPANY	
NAME			POLICY HOLDERS NAME	
MAILING ADDRESS			DATE OF BIRTH	
CITY	STATE	ZIP CODE	SUBSCRIBER ID NUMBER	SOCIAL SECURITY #
HOME PHONE	CELL PHONE	WORK PHONE	SECONDARY INSURANCE INFORMATION	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		INSURANCE COMPANY	
EMPLOYER			POLICY HOLDERS NAME	
EMERGENCY CONTACT PERSON			DATE OF BIRTH	
RELATIONSHIP TO PATIENT	PHONE NUMBER		SUBSCRIBER ID NUMBER	SOCIAL SECURITY #

I understand and agree that I am financially responsible for all charges, whether or not they are paid by insurance. All deductibles, co-pays, and non-covered services are due at the time of service. A 1.5% interest charge will be applied to that portion of the account which is not received 30 days from the statement date.

SIGNATURE:_____DATE: _____