PATIENT REGISTRATION

PATIENT LAST NAME (GENERATION JR., SR.)	FIRST NAME (FULL LEGAL)	MIDDLE NAME	SEX ☐ MALE ☐ FEMALE ☐ OTHER

ADDRESS

CITY	STATE	ZIP	COUNTRY	DATE OF BIRTH

IF YOU WOULD LIKE TO BE CONTACTED VIA EMAIL, PLEASE SUPPLY YOUR EMAIL ADDRESS

HOME PHONE ( )	WORK PHONE ( )	EXT.	CELL PHONE ( )

RACE (Please check one)

☐ White (Non-Hispanic) ☐ Black ☐ Asian
☐ Native American ☐ Hispanic ☐ Other

SOCIAL SECURITY NUMBER

RELIGION

MARITAL STATUS (Please check one)

☐ Married ☐ Widowed ☐ Legally Separated ☐ Registered Domestic Partner
☐ Single ☐ Divorced ☐ Separated ☐ Unmarried

REFERRING PHYSICIAN	If you are not the patient, are you the Legal Representative for the patient? ☐ Yes ☐ No

PATIENT EMPLOYER	PATIENT EMPLOYER'S ADDRESS	PATIENT OCCUPATION

LAST NAME OF RESPONSIBLE PARTY	FIRST NAME	MIDDLE NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER

STREET ADDRESS	APT. NO	CITY	STATE	ZIP

NAME/ADDRESS OF PERSON TO CONTACT IN CASE OF EMERGENCY	EMERGENCY PHONE ( )

COMPLETE THIS SECTION AND PROVIDE A COPY OF INSURANCE CARD

PRIMARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER	INSURANCE WITH ☐ Private ☐ Employer's Group
POLICY HOLDER'S LAST NAME (JR., SR.)	FIRST NAME	MIDDLE NAME	EMPLOYER'S NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE ( )	WORK PHONE ( ) EXT.
CLAIMS ADDRESS		PLAN NUMBER	

PATIENT RELATIONSHIP TO POLICY HOLDER (Please check one)

☐ Adopted Child ☐ Father ☐ Life Partner ☐ Self
☐ Child ☐ Foster Child ☐ Mother ☐ Spouse
☐ Emancipated Minor ☐ Grandfather or Grandmother ☐ Nephew or Niece ☐ Stepson or Stepdaughter
☐ Employee ☐ Grandson or Granddaughter ☐ Other Relationship ☐ Ward

SECONDARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER	INSURANCE WITH ☐ Private ☐ Employer's Group
POLICY HOLDER'S LAST NAME (JR., SR.)	FIRST NAME	MIDDLE NAME	EMPLOYER'S NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE ( )	WORK PHONE ( ) EXT.
CLAIMS ADDRESS		PLAN NUMBER	

PATIENT RELATIONSHIP TO POLICY HOLDER (Please check one)

☐ Adopted Child ☐ Father ☐ Life Partner ☐ Self
☐ Child ☐ Foster Child ☐ Mother ☐ Spouse
☐ Emancipated Minor ☐ Grandfather or Grandmother ☐ Nephew or Niece ☐ Stepson or Stepdaughter
☐ Employee ☐ Grandson or Granddaughter ☐ Other Relationship ☐ Ward

PAYMENT

I hereby state that to the best of my knowledge, the above information is current,correct and true.

PATIENT OR AUTHORIZED SIGNATURE	PRINT NAME

Block 12:
PATIENT'S or AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Refusal to sign will require payment by cash, check or credit card at the time of service.

SIGNED ____________________ DATE ____________________

Block 13:
PATIENT'S or AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Refusal to sign will require payment by cash, check or credit card at the time of service.

SIGNED ____________________