Patient Registration Form

Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

Prefer to be called: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Sex: ☐ M ☐ F

Address: _____
Street # Street Name Apt #

_____
City State Zip

Employer: _____ _____
Name Address

Cell Phone: _____

Home Phone: _____ Work Phone: _____

Date of Birth: ____/____/____ Social Security Number: _____
Month Day Year

If Student ☐ Full Time ☐ Part Time Name of School: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Parent/Next of kin: _____ Spouse's date of birth: ____/____/____
Name Month Day Year

Name of referring Physician: _____

PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

_____ _____
Signature of patient or legal guardian Date

Name of policy owner if other than patient: _____
Date of birth and gender of policy holder: _____
Patient relationship to policy owner: ☐ Self ☐ Child ☐ Other: _____

Please present insurance cards to the receptionist so copies may be made.

Do we have your permission to:

Leave a message on your answering machine at home? ☐ YES ☐ NO
Leave a message at your place of employment? ☐ YES ☐ NO
Discuss your medical condition with any member of your household? ☐ YES ☐ NO
If yes, whom: _____ Relationship _____

_____ _____
Patient Signature / Parent (if Pt Minor) Date