Patient Registration Form

Name:
_____ Jr. Sr.

Date of Birth: _____/____/_____ Sex: **F M** Social Security: _____/____/_____
Address:
_____
Street # Street Name Apt #
_____
City State Zip
Email Address: _____
Day Phone: (_____)_____-_____ Evening Phone: (_____)_____-_____
How did you learn about our practice?
_____
Insurance Information: Do you have insurance? **Yes ( ) No ( )**
Primary Insurance Carrier:_____
Name of Insured (Primary): _____ Date of Birth date: ____/____/____
Secondary Insurance Carrier: _____
Name of Insured (Primary): _____ Date of Birth date: ____/____/____
May we leave personal medical information on your Voicemail at home? Yes ( )No ( )
May we e-mail personal medical information to you? Yes ( ) No ( )
E-mail address: _____
Do you give our office permission to discuss your medical information with family members? Yes ( ) No ( )
If yes, please provide their names and phone numbers below.
Name: _____ Relationship:
_____
Phone # (day): (_____)_____Phone # (evening): (_____)_____

Name: _____ Relationship: _____
Phone # (day): (_____)_____ Phone # (evening): (_____)_____

Emergency Contact Information:
In case of Emergency, whom should we notify?

Please present your insurance card(s) and your photo identification to the receptionist who will make a copy for your file and return them to you promptly. In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial polices of this office.

PAYMENT IS EXPECTED FROM YOU, FOR "YOUR PORTION OF THE CHARGES," AT THE TIME OF SERVICE. For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND BANK DEBIT CARDS. 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) and herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Patient Signature: _____Date: _____/_____/_____

Employment Information:_____

Employer Name:

_____

Address:

_____

Street # Street Name

_____

City State Zip

Phone: _____ Extension: _____

Drivers License Number: _____

Preferred Pharmacy information: _____

Name of Pharmacy:

_____

Address:

_____

Street # Street Name

_____

City State Zip

Phone number: _____ Fax number: _____