Patient Registration Form (Please Print - Complete All Items)

Date: _____

Patient Information: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Single ☐Married ☐Widowed ☐Divorced

Last Name: **First Name:** **Middle Initial:**

Address: **Apt.** **City:** **State:** **Zip:**

Sex: ☐M ☐F **Date of Birth:** ____/____/_____ **Age:** _____ **SS#:** _____ **(Required)**

Home Phone: ( ) _____ **Work Phone:** ( ) _____

Personal Physician?: _____ **Phone:** _____

Referred by?: _____ **Phone:** _____

Employer's Name: **Occupation:**

Employer's Phone: ( ) **Address:**

Emergency Contact: _____ **Relationship:** _____
Phone: ( ) _____

Nearest Living Relative Not Living with You: _____ **Phone:** ( ) _____

********* **PRIMARY INSURANCE INFORMATION** *********

Primary Insurance: _____ **Name of Insured:** _____

Group#: _____ **Policy Number:** _____ D.O.B.: / / Relationship-

********* **SECONDARY INSURANCE COVERAGE** *********

Secondary Insurance: _____ **Policy Number:** _____

Grp#: _____ **Name of Insured:** _____ **D.O.B.:** _____/_____/_____

I request that payment of authorized insurance benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If at the time of service, I state I have valid insurance coverage, but later if it is determined, for whatever reason, I was not covered, I acknowledge and agree that I am responsible for the entire fee. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as co-insurance and the deductible is based upon the charge determination of the Medicare carrier. My signature authorizes release of the information to the insurer or agency shown. I understand that the responsibility of arranging care under a contracted provider or securing authorizations for referrals, tests, labs, etc., lies with the me the Patient/Guardian.

MEDICAL HISTORY

Known Medical Problems: _____
(Include Recent Surgery, _____
Hospitalizations & Approx _____
Dates) _____
What Medications Do You _____
Take Regularly? _____
_____
_____
Allergies: _____

HAVE YOU EVER HAD: ("X" if Yes)
_____ Heart Trouble
_____ High Blood Pressure
_____ Diabetes
_____ Tuberculosis
_____ Peptic (Stomach) Ulcer
_____ Asthma
_____ Hay Fever
_____ Eczema
_____ Glaucoma
_____ Bleeding or Clotting Problem
Are you pregnant? ☐Yes ☐No

_____ _____
Signature of Patient or Guardian Date