Patient Registration Form

Name: _____ ❑ Jr. ❑ Sr.
First *Middle* *Last*

Address: _____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Employer: _____
Name *Address* *Phone*

Home Phone: _____ **Date of Birth:** ____/____/____ **Age:** _____
Month **Day** **Year**

Work Phone: _____ Cell Phone: _____

Last Four Digits of Social Security Number: _____ **Sex:** ❑ **M** ❑ **F**

Primary Care/Family Physician _____
Address Phone No.

_____ _____

Does your insurance require a referral? ❑ Yes ❑ No **e-mail address** _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. HMO PATIENTS MUST HAVE A VALID REFERRAL IN ORDER TO BE SEEN. IF YOU DO NOT HAVE A REFERRAL YOUR APPOINTMENT CAN BE RESCHEDULED OR YOU CAN PAY FOR THE SERVICES THAT ARE RENDERED AT THE TIME OF THE VISIT. If you have no insurance or an insurance in which we do not participate you are responsible to pay for services in full at the time of the visit. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Your signature authorizes the Doctors to release such medical information necessary to process your insurance claims (if any). You authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Name of policy owner if other than patient: _____

Name: _____
Last *First* *M.I.*

Address: _____
City *State* *Zip*

Home Phone _____ Work Phone _____ **SS:** _____
Area Code *Area Code*

Date of Birth: ___/___/___ **Sex** _____

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

OVER

Pharmacy of choice____________________ Address ______________________ Phone ______________

In case of Emergency, who should be notified? ____________________________ Phone ______________

Do we have your permission to:

Leave a message on your answering machine at home? (or cell)? ❑ **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 **Date**

OFFICIAL USE ONLY

❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______
❑ Copy of current insurance cards (both sides)	❑ Updated information	Date______	Initials______