PATIENT REGISTRATION FORM

Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Name: ________________________________ ☐ Jr. ☐ Sr.
First Middle Last

☐ Married ☐ Single ☐ Other __________

Address: ____
Street # Street Name Apt #

____
City State Zip Code

Employer: ____
Name Address Phone

Home Phone: ____________________ Date of Birth: ____________________
Month / Day / Year

Cell Phone: ____________________ E-mail: ____________________

Social Security #: ____________________ Sex: ☐ Male ☐ Female

Emergency Information (Please list someone other than in your household): Name: ____________________

____
Phone Address Apt# City State Zip Code

Spouse: ____________________ Referring Doctor: ____________________

Spouse's Date of Birth: ____________________
Month / Day / Year

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, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. 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 assigned claim is filed.

____________________ ____________________
Signature of Patient or Legal Guardian Date

PRIMARY INSURANCE: ____________________
POLICY #:______________GROUP #:______________________POLICYHOLDER:______________

SECONDARY INSURANCE:________________________
POLICY #:______________GROUP #:______________________POLICYHOLDER:______________

Do we have your permission to:

Leave a message on your answering machine at home?
Leave a message at your place of employment?
Discuss your medical condition with any member of your household?
If yes, whom: ____________________ Relationship: ____________________

____________________ ____________________
Staff Signature Date

MINOR PATIENT REGISTRATION FORM

Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Child's Name: ______________________________ Date of Birth: ______________
First Middle Last Month / Day / Year

Social Security #: ______________________ Sex: ☐ Male ☐ Female

Prefer to be called: ______________________ Referring Doctor: ______________________

Address: ____
Street # Street Name Apt #

____
City State Zip Code

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

Legal Guardian or Parent Name: ____________________________________
First Middle Last

Date of Birth: ______________________ Social Security #: ______________________

Employer: ____
Name Address Phone

Home Phone: ______________________ Parent/Legal Guardian Cell Phone: ______________

E-mail: ______________________

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, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. 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 assigned claim is filed.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

______________________________ ______________________________
Signature of Parent or Legal Guardian Date

PRIMARY INSURANCE: ______________________
POLICY #:______________ GROUP #:______________________ POLICYHOLDER:______________

SECONDARY INSURANCE:______________________
POLICY #:______________ GROUP #:______________________ POLICYHOLDER:______________

Do we have your permission to:

Leave a message on your answering machine at home?

Leave a message at your place of employment?

Discuss your medical condition with any member of your household?

If yes, whom: ______________________ Relationship: ______________

______________________________ ______________________________
Staff Signature Date