Patient Registration Form

Physician Name: _____

Patient Name: _____ Social Security Number:_____-_____-_____

Date of Birth:_____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address:_____

Race:_____ Religion:_____ Primary Language:_____

Home Phone: (_____) _____-_____ Work: (_____) _____-_____ Cell phone: (_____) _____-_____

Primary Phone: (_____) _____-_____ Email Address:_____

How would you like to receive notifications from our office? _____

How did you hear about our Practice:_____

Employer Name and Contact Number: _____

Preferred Pharmacy:

Pharmacy Name:_____ Address:_____

Insurance Information:

Insurance Company:_____ Policy Number:_____ Group Number:_____

Policy Holder:_____ Date of Birth:____/_____/_____

Guarantor Name:_____ Social Security Number: _____-_____-_____

Relationship to patient: (please check): ( ) self, ( ) spouse, or ( ) parent

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder Date of Birth: _____

Guarantor Name:_____ Social Security Number: _____-_____-_____

Relationship to patient: (please check): ( ) self, ( ) spouse, or ( ) parent

Emergency Contact:

Name:_____ Address:_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Relationship:_____

I authorize assignment of insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non covered services. I also authorize the physician to release any information necessary to process an insurance claim. I hereby consent to such diagnostic procedures and treatment deemed necessary or advisable by my physician.

Patient Signature:_____

Parent or Guardian Signature: _____ Date: _____/_____/_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.