

Patient Registration Form

Date: _____

Name: _____ Sex: M F Jr. Sr.
Last First MiddleEmail: _____ Title: Mr. Mrs.
 Dr. Ms. MissAddress: _____
Street # Street Name Apt #
City State ZipSocial Security Number: _____ Date of Birth: _____ / _____ / _____
Month Date Year

Home Phone: () _____ Work Phone: () _____ Cell #: () _____

Employer: _____
Name Address Phone PositionIf Student: Full Time Part Time Name of School: _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____	Secondary Insurance Name _____
Ins. Address _____	Ins. Address _____
Name of Subscriber _____	Name of Subscriber _____
Subscriber's ID # _____ / S.S. # _____	Subscriber's ID # _____ / S.S. # _____
Group # _____ / D.O.B. _____	Group # _____ / D.O.B. _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer Phone () _____	Employer Phone () _____
Relationship of the patient to the Subscriber _____	Relationship of the patient to the Insured _____

Other family members that are patients _____

Pharmacy of Choice/Location _____ Phone () _____

In case of Emergency, who should be notified? _____ Phone () _____

Referred by _____ Phone () _____

Primary Care Physician _____ Phone () _____

I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits and that a finance charge of 1% will accrue on my unpaid balance older than 30 days.

Signature _____ Date _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____ / ____ / ____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.Address _____
City State Zip