

PATIENT REGISTRATION FORM

Account #: _____

PATIENT NAME: _____

BILLING ADDRESS: _____ CITY, STATE ZIP: _____

PERMANENT ADDRESS: _____ CITY, STATE ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____ SEX: *M F* BIRTHDATE: _____ AGE: _____

RELATIONSHIP TO PATIENT: *Self Spouse Child Other*

REFERRING DOCTOR NAME & ADDRESS:
(Or, how did you hear about us?) _____

PRIMARY CARE DOCTOR NAME & ADDRESS: _____

IS PATIENT: *Single Married Other* IS PATIENT: *Employed Full-Time Student Part-Time Student Other*

EMPLOYER NAME/ADDRESS/PHCNE: _____

SPOUSE OR NEAREST RELATIVE NAME/PHONE/ADDRESS: _____

EMERGENCY CONTACT NAME/PHONE/ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: INSURANCE CO. NAME: _____ SECONDARY INSURANCE: INSURANCE CO. NAME: _____

INS. CO. ADDRESS: _____ INS. CO. ADDRESS: _____

POLICY HOLDER NAME: _____ POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: *Self Spouse Child Other* RELATIONSHIP TO PATIENT: *Self Spouse Child Other*

EMPLOYER: _____ EMPLOYER: _____

POLICY NO. : _____ POLICY _____

GROUP/CLAIM NO. : _____ GROUP/CLAIM _____

POLICY HOLDER SEX: *F or M* BIRTHDATE: _____ POLICY HOLDER SEX: *F or M* BIRTHDATE: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment which shall include HIV, communicable disease or drug abuse information.
AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Patient or Parent, if minor): _____ DATE: _____