

NEW PATIENT REGISTRATION
PLEASE PRINT

| PATIENT INFORMATION | | | | | | | | | | | |
|---|--|---------------------|---------------------|-----------|---------------------|-------------------------------------|--|--|---------------------------------------|--------------------|-----------|
| LAST NAME OF PATIENT | | FIRST | | MI | SOCIAL SECURITY NO. | | IS RESPONSIBLE PARTY THE PATIENT? | | HAS RESPONSIBLE PARTY BEEN A PATIENT? | | |
| ADDRESS | | | | | AGE | DATE OF BIRTH | | OCCUPATION | | | |
| CITY | | ST | ZIP CODE | | SEX | DRIVERS LIC. | | RESPONSIBLE PARTY STATEMENT As the responsible party, I agree that all charges incurred are my responsibility on the date of service unless otherwise stated. | | | |
| HOME PHONE () - | | CELL PHONE () - | | | WORK PHONE () - | | RESPONSIBLE PARTY SIGNATURE DATE X | | | | |
| EMPLOYED BY | | YRS | ADDRESS | | | CITY | | ST | ZIP CODE | TELEPHONE () - | |
| REFERRED BY – DOCTOR, PATIENT, HOSPITAL, OR INSURANCE | | | | | | | | | | | |
| LAST NAME | | FIRST | | MI | ADDRESS | | | | TELEPHONE () - | | |
| IN CASE OF EMERGENCY NOTIFY | | | | | | | | | | | |
| LAST NAME | | FIRST | | MI | ADDRESS | | | | TELEPHONE () - | | |
| SPOUSE/GUARDIAN INFORMATION | | | | | | | | | | | |
| LAST NAME OF SPOUSE | | | FIRST | | MI | LAST NAME OF GUARDIAN | | | FIRST MI | | |
| DATE OF BIRTH | | SEX | SOCIAL SECURITY NO. | | | DATE OF BIRTH | | SEX | SOCIAL SECURITY NO. | | |
| EMPLOYED BY | | | TELEPHONE () - | | | EMPLOYED BY | | | TELEPHONE () - | | |
| ADDRESS OF EMPLOYER | | | | | ADDRESS OF EMPLOYER | | | | | | |
| INSURANCE COMPANY INFORMATION | | | | | | | | | | | |
| NAME OF PRIMARY INSURANCE COMPANY | | | | GROUP NO. | | NAME OF SECONDARY INSURANCE COMPANY | | | | GROUP NO. | |
| ADDRESS | | | | | ADDRESS | | | | | | |
| CITY | | ST | ZIP CODE | | TELEPHONE | | CITY | | ST | ZIP CODE | TELEPHONE |
| NAME OF INSURED IF NOT THE PATIENT | | | | | | | | | | | |
| ADDRESS | | | | | SEX | RELATIONSHIP | | | | | |

| PAYMENT OF BENEFITS | | | | MEDICAL RELEASE AUTHORIZATION | | | |
|---|--|--|------|---|--|--|------|
| I authorize payment as determined by the company, directly to the physician. I understand that I may still be responsible for any amounts not paid by my insurance company. | | | | I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. | | | |
| PATIENT OR AUTHORIZED SIGNATURE | | | DATE | PATIENT OR AUTHORIZED SIGNATURE | | | DATE |
| X | | | | X | | | |