

Office Use Only:

Pt. Acct. #

Physician: _____

Patient Registration Form

New

Updated

Patient				
Social Security Number	Last Name	First Name	MI	Maiden Name
Address		City	State	Zip
Home Phone ()	Work Phone ()	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> (M)arried <input type="checkbox"/> (S)ingle <input type="checkbox"/> (D)ivorced <input type="checkbox"/> (W)idowed <input type="checkbox"/> (L)ife Partner			Allergies	
Spouse				

Other Information	
Referred by:	<input type="checkbox"/> Physician (Name _____) <input type="checkbox"/> Patient (Name _____) <input type="checkbox"/> Friend/Relative (Name _____) <input type="checkbox"/> Physician Referral Service (Name _____) <input type="checkbox"/> Insurance Company Directory <input type="checkbox"/> Hospital Staff Directory <input type="checkbox"/> Consulting Nurse Service Advertisement: <input type="checkbox"/> Billboards <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Yellow Pages

Employer		
Employer Name	Phone Number ()	Fax Number ()
Address	City	State Zip
Occupation	Date Started / /	
Student Status <input type="checkbox"/> Non-Student <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	School Name	School Contact Phone ()

Responsible Party (Who is responsible for the remaining balance on this account?)			
Social Security Number	Last Name	First Name	MI
Address	City	State	Zip
Home Phone ()	Work Phone ()	Name of Employer	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> (M)arried <input type="checkbox"/> (S)ingle <input type="checkbox"/> (D)ivorced <input type="checkbox"/> (W)idowed <input type="checkbox"/> (L)ife Partner	
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			

Please Complete Information on Reverse Side

<i>Responsible Party, Continued</i>			
Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Comp Carrier	Claim Number	Date of Injury / /
Comp Carrier's Address		City	State Zip
Employer Contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Employer	Contact Person	Contact Phone ()
Employer's Address		City	State Zip

<i>Primary Insurance</i>			
Insurance Company Name		Subscriber's Name	
Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Subscriber's DOB / /	Subscriber's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber's Employer	Patient's ID #	Group #	Copay Amount
Employer's Address		City	State Zip
Insurance Company Address		City	State Zip

<i>Secondary Insurance</i>			
Insurance Company Name		Subscriber's Name	
Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Subscriber's DOB / /	Subscriber's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber's Employer	Patient's ID #	Group #	Copay Amount
Employer's Address		City	State Zip
Insurance Company Address		City	State Zip

<i>Emergency Contact Information</i>		
Contact Name	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Contact Phone ()

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I hereby accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy of this document is to be considered as valid as an original.

Guarantor Signature: _____ Date: _____