PATIENT REGISTRATION FORM

Email:

Patient Name:

Address: (Street) (Apt. #) (City) (Postal Code)

Phone: Home Work: Ext. Birthdate (Y) (M) (D)

Driver's License #: _____

Occupation: _____ School (if student) _____

Whom may we thank for referring you? _____

Spouse's Name: _____

Parent/Guardian Name (if parent under age of 18) _____

Relationship to Patient: _____

Any other family members in our practice? _____ If yes, whom _____

Emergency Contact Name

Relationship to Patient

Phone: Home Work: Ext. Other #

Some insurance companies now allow claims to be submitted electronically, therefore, allowing you to be reimbursed in only few days. In order for us to assist you with this we require the following information:

SUBSCRIBER:

Name: (First) (Initial) (Last) Phone #:

Address: Birthdate: (Y) (M) (D)

Insurance Co. Policy/Plan # Identification #

Employer

SPOUSE (Complete if spouse is covered under separate policy)

Name: (First) (Initial) (Last) Birthdate: (Y) (M) (D)

Insurance Co. Policy/Plan # Identification #

Employer

I authorize release, to my insurance company/plan administrator, the information contained in claims submitted electronically.

(required before claims can be submitted electronically)

Signature of Patient or Parent/Guardian