

Patient Registration

Please Print

Last Name _____		First _____		MI _____
Date of Birth _____	Sex _____	Social Security # _____		
Address _____		City _____	State _____	
Zip Code _____	Home Phone _____	Work or Cell _____		
E-mail Address _____				

Race: (Please check one)				
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Declined	
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Other Race	<input type="checkbox"/> White		

Ethnicity: (Please check one)				
<input type="checkbox"/> Declined	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Unknown	

Marital Status _____		If Married, Spouse's Full Name _____		
Employer _____	Phone _____			
Emergency Contact _____	Phone _____			
Referring Dr. _____	Patient PCP _____			
Preferred Pharmacy _____	Phone: _____			

Insurance Information				
(If Worker's Comp, please write W/C under Primary Insurance)				
Primary Insurance Plan _____		ID# _____		
Group # _____	Issue Date _____	Phone _____		
Copay Amount _____				
Policy Holder Last Name _____		First _____	MI _____	
Relationship to Patient _____		Policy Holder Date of Birth _____		
Social Security # _____		Sex _____		
Address If Different from Patient _____				
Secondary Insurance _____		ID# _____		
Group # _____	Issue Date _____	Phone _____		
Policy Holder Last Name _____		First _____	MI _____	
Relationship to Patient _____		Policy Holder Date of Birth _____		
Social Security # _____		Sex _____		
Address If Different from Patient _____				

Assignment and Release

I hereby assign my insurance benefits to be paid directly to the physician.
 I understand that I am financially responsible for all non-covered services.
 I authorize the physician to release any information required to process this claim

Signed _____ Date _____