# PATIENT REGISTRATION FORM

Referred By: _____ Date: _____

| **PATIENT INFORMATION:** | | | | |
|---|---|---|---|---|
| Patient's Last Name: | Patient's First Name: | | Middle: | __ Mrs. __ Mr. __ Miss __ Dr. |
| Date of Birth: | Sex: (Check One) __ Female __ Male | Social Security #: | | Race: |
| Address: | | City: | State: | Zip: |
| Home Phone No. | Cell Phone No. | Email Address: | | |
| Please check one: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Seperated | | | Language: | |
| Employer: | | Work Phone No: | | |
| Primary Care Doctor: | | | | |
| **IN CASE OF EMERGENCY** | | | | |
| Emergency Contact/Relationship: | | Emergency Contact Phone: | | |
| **INSURANCE INFORMATION (Please list the policy holder if other than the patient)** | | | | |
| Primary Insurance: | | Secondary Insurance: | | |
| Subscriber Name: | | Subscriber Name: | | |
| Social Security No.: | Date of Birth: | Social Security No.: | Date of Birth: | |
| Patient's Relationship to Insured: __ Self __ Spouse __ Child __ Other: _____ | | | | |
| **PAYMENT AUTHORIZATION** | | | | |

**Authorization to Release and Assign Insurance Benefits**: I hereby authorize the above doctor(s) to furnish any information which my insurance company may request concerning my claim. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to my insurance company. I understand that I am financially responsible to said doctor for charges and any insurance changes. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court costs incurred in attempting to collect on the oustanding balance.

**Office Financial Policies**: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. For your convenience, we offer the following methods of payment.

**CASH CHECK CREDIT CARDS: MASTERCARD VISA DISCOVER AMERICAN EXPRESS**

*****There is a $35.00 fee for a check returned by the bank for any reason.*****

**Missed Appointment Policy**: If you cancel your appointment without **48 hours** notice or do not keep your appointment you will be charged a **$50.00 No Show Fee.**

Your signature below signifies your understanding, acceptance and agreement to our office policies.

_____ _____

Responsible Person's Signature Date

**Patient records only maintained for six (6) years after last encounter (visit)**