DATE: __________

PATIENT REGISTRATION

PLEASE PRINT & COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MI)		STREET ADDRESS:	

CITY, STATE, ZIP	HOME PH:	CELL:	BEST CONTACT# (HOME OR CELL)

DATE OF BIRTH:	SSN:	SEX: _M _F	MARITAL STAT: _S _M _O

INSURED/RESPONSIBLE PARTY INFORMATION

NAME: (LAST, FIRST, MI)	ADDRESS (IF DIFF FROM ABOVE)	PHONE:
SSN: (IF DIFF FROM ABOVE)	DATE OF BIRTH:	EMPLOYER:

INSURANCE INFORMATION

PRIMARY INSURANCE CO:	ADDRESS:	PHONE:
ID NUMBER:	GROUP NUMBER:	EMPLOYER:
SECONDARY INSURANCE CO:	ADDRESS:	PHONE:

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	PHONE:

I hereby authorize my insurance benefits be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE	DATE:

EMAIL:

***PLEASE TELL US: HOW DID YOU HEAR ABOUT US?_**