

**PATIENT REGISTRATION FORM:**

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| LAST NAME: _____<br>FIRST NAME: _____<br>ADDRESS: _____<br>CITY, STATE, ZIP: _____<br>PHONE (MOBILE): _____<br>SECONDARY PHONE (HOME AND WORK): _____<br>EMAIL: _____ | SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Date of Birth: _____<br>Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Others<br>Referring physician: _____<br>Primary care Physician: _____<br><input type="checkbox"/> Power of Attorney if yes, Name _____ and<br>Relation _____ |
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| Emergency Contact:<br>Name: _____<br>Contact Phone No. _____ | Patient Employment:<br>Employer Name: _____<br>Phone: _____<br>Occupation: _____ |
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| Person Responsible for Payment:<br>( <input type="checkbox"/> ) Same as patient | If not, Name: _____<br>Address: _____<br>City, State, ZIP: _____ |
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| Primary Insurance:<br>( <input type="checkbox"/> ) Same as patient<br>Subscriber Name: _____<br>Subscriber Phone: _____<br>Insurance Company: _____ | Insurance ID: _____<br>Group #: _____<br>If applicable, Patient relation to insured:<br>_____ |
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| Secondary Insurance:<br>( <input type="checkbox"/> ) Same as patient<br>Subscriber Name: _____<br>Subscriber Phone: _____<br>Insurance Company: _____ | Insurance ID: _____<br>Group #: _____<br>If applicable, Patient relation to insured:<br>_____ |
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Physician, providers and practice agrees to accept Medicare payments in full except for the deductible, co-insurance and non-covered services. These charges will be your responsibility to pay.

Co-insurance payments are due at the time of service.

I understand I am responsible for obtaining a referral from my primary care physician if one is required. I accept financial responsibility for all account balances over 60 days. Any accounts that are referred for collection will be charged reasonable collection fees and attorney fees.

I authorize the doctor to release information to my referring doctor and/or my insurance company. I authorize all insurance benefits to be paid directly to the doctor.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_