Registration Form

PCP/Referring Physician: _____

Date Last Seen: _____/_____/_____

Patient Information

Last Name: _____First Name: _____MI: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ AGE: _____ Maiden Name: _____

Gender: ☐ *Male* ☐ *Female*

Race: Check One: ☐ *White* ☐ *Asian* ☐ *Black/African Amer.* ☐ *Amer. Indian or Alaska Native* ☐ *Native Hawaiian or Other Pacific Islander* ☐ *Other*

Ethnicity: Check One: ☐ *White* ☐ *Asian* ☐ *Black/African Amer* ☐ *Hispanic or Latino or Spanish*

Marital Status: Check One: ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* ☐ *Separated*

Address: _____

City: _____State: _____ Zip Code:_____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

Email: _____Fax: (____)_____ Preferred Method of Contact: _____

Employment Status: _____ Employer: _____

Remarks: _____

Reason for Visit: _____

Is your visit due to a job related injury or automobile accident? Y _____ N_____

If yes then please provide Date of Injury/Accident: ____/____/_____

Responsible Party Information

Last Name: _____ First Name: _____MI: _____

Relation with patient: _____ SSN: _____-_____-_____ DOB: ____/____/_____

Gender: ☐ *Male* ☐ *Female*

Address: _____

City: _____State: _____ Zip Code:_____

Insurance Information

Primary Payer Name: _____

Address: _____ Phone: (____)_____

Insured Id: _____Effective Date: _____/_____/_____Expiration Date: ____/____/_____

Group Name: _____Group Number: _____

Insured: **SELF _____ IF NOT:**

Last Name: _____First Name: _____MI: _____

Relation with patient: _____ SSN: _____-_____-_____ DOB: ____/____/_____

Address: _____

City: _____State: _____ Zip Code:_____

Secondary Payer Name: _____

Address: _____ Phone: (____)_____

Insured Id: _____ Effective Date: _____/_____/_____Expiration Date: ____/____/_____

Group Name: _____ Group Number: _____

Insured: **SELF _____ IF NOT:**
Last Name: _____First Name: _____MI: _____
Relation with patient: _____ SSN: _____-_____-_____ DOB: ____/____/_____
Address: _____
City: _____State: _____ Zip Code:_____

Emergency Contact
Name: _____ Relationship: _____
Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Medical Information
Pharmacy Name: _____ City/Town & State: _____

Medications: _____

_____

_____

Allergies:

_____

_____

_____

HIPAA INFORMATION

I authorize the office to contact me at : ☐ Home ☐ Work ☐ Mobile ☐ Email ☐ Any of the communication mode

I authorize the office to leave me messages at: ☐ Home ☐ Work ☐ Mobile ☐ Email ☐ Any of the communication mode.
It is not possible to guarantee the security of email exchanges.

Insurance Authorization and Assignment

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE COMPANY BENEFITS BE MADE TO DR. _____ FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES.
I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM IN MEDICARE OR INSURANCE COMPANY ASSIGNEDCASES. THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINED BY MEDICARE OR MY INSURANCE COMPANY AS PAYMENT IN FULL. I AM RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE, OR NON-COVERED SERVICES.

SIGNATURE: _____ DATE: _____

Your health information will be kept confidential. Any information we collect about you on this form will be kept confidential in our office. Your health information will be shared with insurance carriers for billing purposes only.