Patient Registration

Welcome to our office. In order to serve you properly, we will need you to verify or enter the following information.
(Please Print)
All information will be strictly confidential.

First name: _____ MI: _ Last: _____ Birth dt: _____ Age: ___

Address: _____ SS#: _____

City/St/Zip: _____ Marital Status: _____

Home Tel#: _____ Work Tel#: _____ Cell#: _____

Sex: _ Email adr: _____

Name of Employer: _____ Occupation: _____

Address: _____

Primary Insurance Company: _____

Please Circle: Health Workers Compensation Motor Vehicle

Address: _____ Tel: _____

Policy#: _____ Group#: _____ Claim#: _____

Subscriber Name: _____ Birth dt: _____

Date of accident(If WC/MV): _____ Attorney: _____

Attorney Address: _____

Secondary Insurance: _____

Address: _____ Tel: _____

Policy#: _____ Group#: _____

Subscriber Name: _____ Birth dt: _____

Insurance Authorization for Assignment of Benefit/Information Release

I, the undersigned, authorize payment of medical benefits to this facility for any services furnished by the physicians in this facility. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agents (including Medicare), information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits.

_____ _____

Patient Signature Date

We require a copy of your insurance cards as well as one form of ID (preferably a drivers license). Thank you.