

GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____
Date of Birth: _____
Marital Status: Single Married Separated Divorced Widowed
Sex: Male Female
Social Security Number: _____
Email Address: _____
Home Phone Number: _____
Cell Phone Number: _____

Drivers License

State: _____
Number: _____

Home Address:

Address: _____
City, State and ZIP: _____

Billing Address:

Address: _____
City, State and ZIP: _____

Work Information

Employer: _____
Occupation: _____
Work Phone Number: _____

Method of Contact: Phone Email Either Phone or Email

Emergency Contact:

Full Name: _____
Phone Number: _____
Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

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Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____
Social Security: _____
Relation to Patient: _____

Primary Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
Social Security: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Secondary Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
Social Security: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Medicaid Number: _____

I authorize the medical doctor to release any information, including diagnosis, treatment plans/records and radiographs to third party payors and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the medical group or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____