PATIENT REGISTRATION FORM

PATIENT NAME:____
Last First

ADDRESS:____

TELEPHONE:(   ) ______________________ (   )___________________________
Home work / cell / other

DOB:_______________ **SS#**:________________________**OCCUPATION**:_______________

REFERED BY:___________________________ **E-MAIL**:___________________________

PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

INSURANCE INFORMATION

INSURED NAME:____ **DOB:**_______________
Last First

ADDRESS:____

TELEPHONE:(   )____________________________ (   )___________________________
Home work / cell / other

EMERGENCY CONTACT PERSON NAME:____

RELATION TO PATIENT:________________________________ **PHONE:** __________________

PCP NAME: ____ **PHONE :**________________

PHARMACY NAME:_____________________________________**PHONE:** _________________

IS THIS AN ACCIDENT? ☐ **YES** ☐ **NO** **IS THIS MVA?** ☐ **YES** ☐ **NO**

AUTHORAZATION TO RELEASE INFORMATION & PAYMENT REQUEST

- INSURANCE BILLING : I HEREBY AUTHORIZE TO FURNISH MY INSURANCE. CO. ALL INFORMATION WHICH THE INSURANCE CO. MAY REQUEST CONCERNING MY PRESENTS ILNESS OR INJURY
- I HEREBY ASSIGN TO INSURANCE BENEFITS, INCLUDING MAJOR MEDICAL AND MEDICARE, TO WHICH I AM ENTITED. THE ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE AS VALID AS THE ORIGINAL.
- VALUABLES: I UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR LOSS OF DAMAGE TO OR THEFT OF MY PERSONAL POSSESSION WHILE I AM ON THE PREMISES.

SIGNATURE:_______________________________ **DATE** ______________