



Patient Registration Form

Is today's visit work related?

If yes, do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? Yes No

How did you hear about us? _____

What's the reason for your visit today? _____

PATIENT INFORMATION

Name: _____ Male Female

Date of Birth: _____ SS#: _____

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____ Cell Ph#: _____

*Confidential Phone: _____

Home Email: _____

*Confidential Email: _____

**For more information on the confidential phone and email, please see the attached consent form.*

Primary Care Physician (PCP): _____

PCP Address: _____

PCP Ph#: _____

Preferred Pharmacy: _____

Pharmacy Ph#: _____

Sexual Orientation: _____

Gender ID: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Home Ph#: _____

Cell Ph#: _____

Based on government regulations, we are required to ask the following:

What is your preferred language: _____

Race: _____ I prefer not to answer

Ethnicity: _____ I prefer not to answer

Best Form of Contact: Cell Home Email Mail

Best Time to Call: _____ May we leave a message? Yes No

INSURANCE INFORMATION

Primary Ins: _____ Ins #: _____

Name of Insured: _____

Date of Birth: _____

Relationship to Patient: Self Spouse Parent Other

Secondary Ins: _____ Ins #: _____

Name of Insured: _____

Date of Birth: _____

Relationship to Patient: Self Spouse Parent Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

Check if same as patient information. If not, please complete the entire section.

Name: _____ Male Female

Date of Birth: _____ SS#: _____

Relationship: _____

Phone #: _____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature _____

Date _____

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature _____ Date _____

Signature _____ Date _____