



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	Primary Care Physician (PCP): _____
Date of Birth: _____	SS#: _____		PCP Address: _____
Mailing Address: _____	Apt#: _____		PCP Ph#: _____
City: _____	State: _____	Zip: _____	Preferred Pharmacy: _____
Home Ph#: _____	Cell Ph#: _____		Pharmacy Ph#: _____
*Confidential Phone: _____			Sexual Orientation: _____
Home Email: _____			Gender ID: _____
*Confidential Email: _____			

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

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 _____