



# 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

Name: \_\_\_\_\_  Male      Female

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

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

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 \_\_\_\_\_