

## PATIENT REGISTRATION

Are you presently under the care of a family physician? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the physician's name? \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Phone \_\_\_\_\_

Please fill out this information so we can send your physician a letter regarding our findings during your new patient visit.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Cell Phone or other alternate phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative (not living with you) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### Medical Insurance Information

Member Name \_\_\_\_\_

Member SSN \_\_\_\_\_ Member Date of Birth \_\_\_\_\_

Member's employer \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Insurance Carrier Address \_\_\_\_\_

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### Secondary Insurance Information

Member Name \_\_\_\_\_

Member SSN \_\_\_\_\_ Member Date of Birth \_\_\_\_\_

Member's employer \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Insurance Carrier Address \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

#### ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits  
Paid to myself or the named provider for  
Professional services rendered.

#### RELEASE OF INFORMATION

I authorize the release of any medical information necessary  
to process this claim. I authorize this office to initiate a complaint  
With the insurance commissioner on my behalf if necessary  
To collect payment on a claim.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_