Patient Registration Form

Name_____ Birthday_____ Male_____ Female_____

LAST FIRST MI

Address _____ Apartment #_____

City _____ State_____ Zip_____

Phone: (HOME) _____(WORK)_____(CELL)_____

SS#_____Occupation_____Employer_____

STUDENT: Full time_____ Part time_____ School_____

Married____ Single____ Other_____

Email:_____

Person Responsible For Account If Other Than Patient:

Name:_____ Relationship:_____

Address:_____Phone:_____

Birthday: _____

PRIMARY INSURANCE_____

ID#_____**GROUP#**_____

If insured party is other than patient please complete the following:

Insured's Name_____ Birthday _____

Employer_____ Patients Relationship: SPOUSE___ CHILD___

If you would like us to bill a secondary insurance for you, please check here and provide information on the back of this form.

How did you hear about us? Please check below:

____GE Phone Book ___Advertisement ___Insurance List

____MAC Gregor Phone Book ____Hospital ____Office Sign

____Friend/Relative_____

____Physician_____

Release of benefits and information; I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due, I authorize the doctor or insurance company to release any information required to process this claim. **ASSIGNMENT OF BENEFITS: I am responsible for acquiring a referral if one is required. I am financially responsible for ALL charges.**

_____

Signature **Date**