

PATIENT REGISTRATION

PATIENT NAME

SSN: _____

Last _____ First _____ Middle _____

Marital Status: Single Married Divorced Separated Dependant Birthdate _____

Home Address _____ Home Phone () _____

Street _____ City _____ State _____ Zip _____

Mailing Address _____

Street/PO Box _____ City _____ State _____ Zip _____

(If different from Street Address)

Employment Status: Retired Employed Unemployed Student

Employer _____ Occupation _____

Address: _____ Work Phone () _____

Street _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY (PERSON RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT)

Self (Same as above)

Parent

Spouse

SSN: _____

Last _____ First _____ Middle _____

Relationship to Patient : Husband Wife Mother Father Other Birthdate _____

Home Address _____ Home Phone () _____

Street _____ City _____ State _____ Zip _____

Status (check one) Retired Employed Unemployed Student

Employer _____ Occupation _____

Address _____ Work Phone () _____

Street _____ City _____ State _____ Zip _____

In case of EMERGENCY:

Relative to contact: _____ Phone () _____

**** If you are 65 or older please answer the following questions:**

- Are you employed and covered under an employee health plan ?
- Is your spouse employed and are you covered under your spouse's employee health plan ?
- Do you have any medical coverage other than Medicare? (private insurance, DHS, VA)

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

} if you answer YES to any of these questions, Medicare may not be your primary ins.

How do you intend to Pay? Cash Check Credit Card Insurance

PRIMARY INSURANCE CO.

Phone () _____

Policy/ID Number _____ Group# _____

Insured's Name _____ Relationship to Patient: Self Spouse Dependent Parent

Birthdate of Insured : _____

SECONDARY INSURANCE CO.

Phone () _____

Policy/ID Number _____ Group# _____

Insured's Name _____ Relationship to Patient: Self Spouse Dependent Parent

Birthdate of Insured : _____

Reason for this visit Illness Injury Job related injury Auto Accident Date of Injury/Accident:

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature _____

Date _____