



Patient Registration Information

Please print

Patient's name: _____
Last First M.I.

Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Social Security _____
Sex: M/F Marital status _____ Age _____ Birth date _____

Employed by _____ Address _____
Occupation _____ Bus. phone _____

Spouse's name _____ Occupation _____
Employed by _____ Address _____ Bus. phone _____

Children's names:

May we release medical information to your spouse? Yes No

Responsible Party Information (Only if other than patient)

Name (Last, First, MI): _____ Phone _____
Address: _____
Street City State Zip

Referred by _____
Primary Care Physician _____

Nearest friend or relative not residing with you Relationship Phone

INSURANCE INFORMATION

<p>Primary Insurance</p> <p>Name of Carrier _____ Street Address _____ City, State, Zip _____ Insurance ID No. _____ Group # _____ Subscriber _____ Social Security # _____ Relationship to patient _____ Subscriber Birth date _____ Employers Insurance Plan <u>Yes/No</u></p>	<p>Secondary Insurance</p> <p>Name of Carrier _____ Street Address _____ City, State, Zip _____ Insurance ID No. _____ Group # _____ Subscriber _____ Social Security # _____ Relationship to patient _____ Subscriber Birth date _____ Employers Insurance Plan <u>Yes/No</u></p>
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I ACKNOWLEDGE THAT PAYMENT IS DUE ON RECEIPT OF A STATEMENT FOR SERVICES RENDERED. I AGREE TO PAY A LATE PAYMENT CHARGE OF 1% PER MONTH ON THE UNPAID BALANCE OF MY ACCOUNT THAT IS DELIQUENT 60 DAYS OR MORE. IF MY ACCOUNT IS REFERRED TO COLLECTION, I ALSO AGREE TO PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSES.