REGISTRATION

PLEASE PRINT PLEASE CHECK PAY STATUS: ( ) HMO ( ) PPO ( ) SELF PAY

DATE_____HOME PHONE_____CELL PHONE_____

PATIENT INFORMATION:

NAME_____SOCIAL SECURITY#_____

ADDRESS_____

CITY_____STATE_____ZIP_____ ( ) MALE ( )FEMALE

BIRTHDAY_____ ( )SINGLE ( ) MARRIED ( )WIDOWED ( )SEPARATED ( ) DIVORCED

PATIENT EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____

WORK PHONE_____ PATIENT EMAIL ADDRESS_____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____#_____

PHARMACY NAME_____PHARMACY PHONE NUMBER_____

( )WHITE ( )AMERICAN INDIAN/ALASKA NATIVE ( )ASIAN ( )BLACK/AFRICAN AMERICAN NATIVE

( ) HAWAIIAN/OTHER PACIFIC ISLANDER ( )HISPANIC/LATINO ( )NOT HISPANIC/LATINO ( )OTHER RACE

PRIMARY INSURNACE:

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATION TO PATIENT_____BIRTHDAY_____SOCIAL SECURITY #_____

ADDRESS(IF DIFFERENT FROM PATIENT)_____

PERSON RESPONSIBLE EMPLOYEED BY_____OCCUPATION_____

INSURANCE COMPANY_____

SUBSCRIBER NUMBER_____GROUP NUMBER_____

NAMES OF OTHER DEPENDENTS COVERED UNDER PLAN_____

IF YOU HAVE A SECONDARY INSURNACE PLEASE INFORM FRONT DESK

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH_____

AND ASSIGN DIRECTLY TO DR._____ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUMISSIONS.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE