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REGRISTRATION FORM

NAME:

Last First Middle Initial

STREET: CITY:

STATE: ZIP CODE:

HOME PHONE: CELL: WORK:

BIRTH DATE: / / SS#: SEX: M__ F__

MARITAL STATUS: MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED_____

EMPLOYERS NAME/ ADDRESS:

SPOUSES NAME/ PHONE:

SPOUSES EMPLOYER:

REFERRING DOCTOR:

DO YOU HAVE MEDICARE: YES__ NO___ MEDICARE #:

IS IT YOUR: PRIMARY_____ SECONDRY____

PRIMARY INSURANCE COMPANY:

ID#: GROUP #:

PATIENT RELATIONSHIP TO INSURED: SELF____ SPOUSE____ CHILD____ OTHER____

INSURED'S NAME (if not the same):

SECONDARY INSURANCE COMPANY:

ID#: GROUP #:

PATIENT RELATIONSHIP TO INSURED: SELF____ SPOUSE____ CHILD____ OTHER____

INSURED'S NAME, IF NOT THE SAME:

STREET: CITY:

STATE: ZIP CODE:

I authorize any holder of medical or any other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits either to myself or to the party who accepts assignment.

If you belong to an HMO to which the practice participates, the patients' responsibility is restricted to the applicable co-pay.

SIGNED: DATE:

_____ _____

IN CASE OF EMERGENCY PLEASE NOTIFY: NAME:

PHONE#: RELATIONSHIP: