Patient Registration

Person Responsible for Account

First Name : _____ Last Name : _____ M.I. : _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Text Messages OK? ◯ Yes ◉ No

Birth Date _____

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____

Social Security Number _____ E-mail Address _____

How did you hear about our office? _____

I understand that payment is expected at time of services. Interest will be incurred after 3 months from date of services.

I ACCEPT RESPONSIBILITY FOR THIS ACCOUNT (sign): _____ Date: _____

Spouse Information

First Name : _____ Last Name : _____ M.I. : _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Text Messages OK? ◯ Yes ◉ No

Birth Date _____

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____

Social Security Number _____ E-mail Address _____

Dependent Information (If more than 3, please print and add remaining on reverse side)

	Last Name	First Name	M.I.	Sex	Birth Date	Social Security # (optional)
1						
2						
3						

Notify in Case of Emergency:	Relationship:

Insurance Information

Responsible Person's Insurance Information	Spouse's Insurance Information
Insurance Company Name and Address	Insurance Company Name and Address
Subscriber Name:	Subscriber Name:
Subscriber ID number:	Subscriber ID number:
DOB:	DOB:
Mailing Address:	Mailing Address:
Group Name:	Group Name:
Group Number:	Group Number:

The undersigned(s) hereby authorize the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Authorized Signature of Covered Person	Date:	Authorized Signature of Covered Person	Date:

Print Form

Submit by Email