

## Patient Registration

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
First Middle Initial Last

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip: \_\_\_\_\_

Marital Status:  Married  Single  Other \_\_\_\_\_ Sex  M  F

Home Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of physician who referred you (if applicable): \_\_\_\_\_

**\*\*PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST\*\***

In case of an emergency, please contact: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Do we have permission to:

Leave a message on your answering machine at home or on cell?  Yes  No

Leave a message at your place of employment?  Yes  No

Discuss your medical condition with family member?  Yes  No

If yes, please give name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Payment is due at the time service is rendered for co-pays, deductibles, co-insurance amounts and any other services or treatment not reimbursed by your insurance. Cancellations with less than 24 hours notice are subject to a \$50.00 charge. Returned checks will incur a \$30.00 fee. Accounts with balances owing after insurance determination, are due in full within 30 days of our statement to avoid a \$25.00 rebilling fee.

This office has provided its Notice of Privacy Practices for me to review.

My signature authorizes this office to release information for treatment, payment and health care operations and certifies that I have read and understand the financial policies of this office.

\_\_\_\_\_  
Signature of patient or legal guardian Date: \_\_\_\_\_