

PATIENT REGISTRATION FORM

PLEASE PRINT

DATE: / /
MONTH/DAY/YEAR

PATIENT INFORMATION

PATIENT NAME			<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> MALE
			<input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER	<input type="checkbox"/> FEMALE
LAST	FIRST	MIDDLE	REFERRING PHYSICIAN	FAMILY PHYSICIAN
STREET ADDRESS/P.O. BOX			HOME PHONE NUMBER () _____ - _____	DATE OF BIRTH ____/____/____ MONTH/DAY/YEAR
CITY/STATE/ZIP CODE			SOCIAL SECURITY NUMBER ____ - ____ - ____	
EMPLOYER			EMPLOYER'S PHONE NUMBER () _____ - _____	
EMERGENCY CONTACT : _____			PHONE NUMBER FOR EMERGENCY CONTACT: () _____ - _____	

HOW MAY WE CONTACT YOU REGARDING YOUR MEDICAL INFORMATION, TEST RESULTS, ETC.?

- CALL MY HOME CALL MY WORK USE THE U.S. MAIL CALL MY CELL PHONE (# _____)
 NAME, RELATIONSHIP & PHONE NUMBER OF PERSON WE MAY CONTACT IF UNABLE TO REACH YOU:

NAME	PHONE NUMBER
NAME	PHONE NUMBER

SPOUSE'S NAME <input type="checkbox"/> NOT APPLICABLE	SPOUSE'S DATE OF BIRTH ____/____/____ MONTH/DAY/YEAR	SPOUSE'S SOCIAL SECURITY NUMBER ____ - ____ - ____
FIRST MI LAST		
SPOUSE'S EMPLOYER		SPOUSE'S EMPLOYER'S PHONE NUMBER

INSURANCE

ARE YOU COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU COVERED BY MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY INSURANCE COMPANY	POLICY HOLDER:
	POLICY HOLDER'S DATE OF BIRTH: ____/____/____ MONTH/DAY/YEAR
	POLICY HOLDER'S EMPLOYER:
SECONDARY INSURANCE COMPANY	POLICY HOLDER:
	POLICY HOLDER'S DATE OF BIRTH: ____/____/____ MONTH/DAY/YEAR
	POLICY HOLDER'S EMPLOYER:

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions, provided my insurance card(s) to be copied, and certify this information is true to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information.

SIGNATURE	DATE: ____/____/____ MONTH/DAY/YEAR
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I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits.

SIGNATURE	DATE: ____/____/____ MONTH/DAY/YEAR
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