Patient Registration Form

Patient Information:

____ Male ____ Female ____ Single ____ Married

Last name : _____ First Name: _____ Middle Initial: _____

Address:_____

Patients Date of Birth:_____

Driver's License Number or State ID/Issued by the State of : _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

**Please mark off authorizing consent to reach you (circle preferred method of contact) :*

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

Occupation: _____ Employer: _____

Emergency Contact: Name :_____ Relationship:_____

Telephone number (s): _____

Who is Legally Responsible For Payment On This Account:

___ Self ___ Spouse ___ Parents ____ Mother ____Father ___Other

Please Print Name of Responsible Party:_____

Best Contact Phone Number: _____

Address *(if different from the patient)*:

_____

Email: _____

Relationship to patient:_____

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For patients 18 and younger, or if under guardianship:

Minor lives with primarily with :

____ Both parents ___Mother ___Father ___Other (specify)_____

Please name legal guardians if not parent (s)_____

First Parent's Name:_____ Date of birth:_____

Driver's License: _____

Address (if different) : _____

Occupation: _____ Employer: _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

Please mark off authorizing consent to reach you:

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

Second Parents Name:_____ Date of

birth:_____

Driver's License: _____

Address (if different) : _____

Occupation: _____ Employer: _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

Please mark off authorizing consent to reach you:

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

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Payment in full is due at the time of service. As a courtesy this office will submit a claim on your behalf to the primary insurance you place on file. These benefits will process toward any available out-of-network benefit. If there are benefits payable, the insurance company will send reimbursement directly to the policyholder.

Primary Insurance Coverage

Name of Policyholder : _____

Policyholder Date of Birth: _____

Primary Insurance Company: _____

Contract/Policy Number :_____

Contract/Policy Group Number:_____

Contract effective date: _____

Relationship to Cardholder:_____

PLEASE SIGN BELOW :

My signature on this form serves as consent to submit an insurance claim to the insurance company I have placed on file. I acknowledge this claim will be sent electronically. If I seek care outside of the contract, I am aware that it is my responsibility to obtain prior authorization for services if required by my insurance plan. I am aware that I am responsible for all the charges that are incurred. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other payments that may be deemed my responsibility by the payment sources and required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If per the insurance company mandates in accordance to my plan; I consent to assign all payments for services to the provider.

Print name of Person responsible for payments: _____

Signature: _____Date:_____