

***MUST HAVE SS# OR BD OF -
PERSON WHO HOLDS INS IN
ORDER TO FILE INSURANCE**

PATIENT REGISTRATION FORM
(PLEASE PRINT)

DATE _____

Patient's Name _____ Birthdate _____
Patient's Address _____ Phone # _____
City _____ State _____ Zip code _____ Smoker? _____
S.S. # _____ Marital Status _____ Cell# _____
Patient's Employer _____ Occupation _____
Employer's Address _____
City _____ State _____ Zip code _____ Phone # _____
Referring Dr. _____ Referring Patient _____
If Student, Part-time or Fulltime; School? _____

PERSON WHO HOLDS INSURANCE INFORMATION

Spouse or Parent Name _____ Birthdate _____
Spouse or Parents Address _____
City _____ State _____ Zip code _____ Phone # _____
S.S. # _____ Spouse/Parent Occupation _____
Spouse or Parents Employer _____
Employer's Address _____
City _____ State _____ Zip code _____ Phone # _____
In case of Emergency call: _____ Phone # _____
Relationship _____

Primary Insurance Company Name _____ Effective Date: _____
Primary Insurance Co. Address _____
City _____ State _____ Zip code _____ Phone # _____
Policy # _____ Group # _____ Plan Code # _____
Name of Person Holding Ins. _____ Relationship _____
Secondary Insurance Company Name _____ Effective Date: _____
Insurance Co. Address _____
City _____ State _____ Zip code _____ Phone # _____
Policy # _____ Group # _____ Plan Code # _____
Name of Person Holding Ins. _____ Relationship _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance.

Patient's Signature (parent or guardian, if minor)

Date

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by the above named physician(s) to be made directly to him, regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

Patient's Signature (responsible person, policy owner, insured)

Date

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program to be made either to me or to the above named physician(s).