Date _____ (PLEASE PRINT) Home Phone (____)_____

– Patient Information –

Name _____ email: [redacted] _____
Last Name First Name Middle Initial

Address _____ Cell Phone (____)_____

City _____ State _____ Zip_____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered for _____ years

Patient Employer/School _____ Occupation_____

Employer/School Address _____ Employer/School Phone (____)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

– Primary Insurance –

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

– Additional Insurance –

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate_____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

– Assignment and Release –

I certify that I, and/or my dependent(s), have insurance coverage with — above Listed — and
Name of Insurance Company(ies)

assign directly to ~~Dr~~ Ron French, OT, CHT all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

– Registration Form –