PATIENT REGISTRATION FORM

TODAY'S DATE: _____

NAME: FIRST _____ M.I. LAST _____

HOME ADDRESS: _____ City _____ State _____ Zip _____

HOME PHONE ( ) _____ **WORK PHONE** ( ) _____

CELL PHONE ( ) _____ **EMAIL ADDRESS:** _____

BIRTHDATE: _____ **AGE** _____ **SEX** (CIRCLE) M F

RELATIONSHIP STATUS (CIRCLE) SINGLE MARRIED WIDOWED DIVORCED DOMESTIC PARTNER

SOCIAL SECURITY NUMBER: _____

PATIENT'S EMPLOYER: _____ **PATIENT'S OCCUPATION:** _____

SPOUSE/PARTNER'S NAME: _____

EMERGENCY CONTACT: _____ **PHONE ( )** _____

REFERRED BY: _____

I HAVE READ THE NOTICE OF PRIVACY PRACTICES _____ **(SIGN)**

If you are not the policy holder:

Name of Policy Holder: _____ Policy Holder's Date of Birth _____

AUTHORIZATION FORM

PATIENT NAME _____DATE_____

AUTHORIZATION FOR TREATMENT

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or designated providers.

ASSIGNMENT OF INSURANCE BENEFITS

I herby assign payment directly to physician for services covered by insurance. I assume financial responsibility for, and agree to make payment in full to this physician for all charges for services or medical supplies furnished, not covered or paid by my insurance carrier.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize this physician to release to my insurance carrier and its designated agents any information concerning medical care, advice, treatment, or supplies provided to the patient for purposes of administration, review, investigation, or evaluation of coverage claims and utilization of services. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization form is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN _____

PRINT NAME _____