

Patient Registration

Patient _____ Last Name _____ First Name _____ Middle Initial _____

Sex M F Age _____ Date of Birth MM / DD / YYYY Social Security No. _____

The following questions are required by federal regulations

Which category or categories best describe your race?		Do you consider yourself Hispanic or Latino?
<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Yes
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> No
<input type="checkbox"/> Asian	<input type="checkbox"/> Unable or unwilling to provide this information	<input type="checkbox"/> Unable or unwilling to provide this information

What is your preferred language including those for the hearing impaired? _____

Marital Status S M W D Sep. Spouse (or parent if a minor) _____ Last Name _____ First Name _____

Home Address _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Employer _____ How Long _____ Occupation _____

Employer's Address _____ Street _____ City _____ State _____ Zip Code _____

Emergency Contact _____ Last Name _____ First Name _____ Relationship _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone _____

Referring Physician / Source _____ Phone _____

Primary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name _____ Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

Secondary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name _____ Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policy and procedures.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient