

PATIENT REGISTRATION FORM

Primary Language Spoken: _____ Date: _____

Patient Name: _____ Patient Phone: _____
Last *First* *MI*

Parent/Guardian: (if minor) _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: (if different from above) _____

Birthdate: _____ Sex: M/F SSN: _____ Marital Status: _____

Employer: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Phone #: _____

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT: I authorize treatment of patient named above and agree to pay all charges at the time services are rendered unless other arrangements have been agreed upon in advance. If payment of my account is over 60 days late, or it goes to collection, all fees, including collection fees, attorney fees and finance charges (18% APR) will be my responsibility. I hereby authorize the release of any information necessary for payment of charges incurred.

Signature: _____ Date: _____ Relationship: _____

If the PATIENT is a MINOR, I authorize medical care to be provided if I am not present.

Signature: _____ Date: _____ Relationship: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services provided to me or my dependents. I further agree that should the amount to be insufficient to cover the entire medical and surgery expense, I will be responsible for payment of the difference, and if the nature of the disability is such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signature: _____ Date: _____ Relationship: _____