REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION Date: _____

SS # _____ Primary Phone ( ) _____

_____

Last Name First Name Middle Initial

_____

Address

_____

City State Zip

Sex: Male _____ Female _____ Age: _____ Birth Date: _____

Married ____Separated ____Widowed ____Divorced ____Single ____ Minor ____Partnered for ____ years

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Phone ( )_____

Whom may we thank for referring you? _____

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

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company

and assign directly to Dr. _____ 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 determine 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, Guardian, or Personal Representative Date