

## Patient Registration

### Who Referred You? How Did You Hear About Us? *(please select and specify all that apply)*

<input type="checkbox"/> Physician* <input type="checkbox"/> Self-referred <input type="checkbox"/> Internet/Web Site <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Friend/Other Patient	<input type="checkbox"/> Television _____ <input type="checkbox"/> Radio _____ <input type="checkbox"/> Magazine _____ <input type="checkbox"/> Newspaper _____ <input type="checkbox"/> Other _____	*Physician Name _____ Street Address _____ City _____ Phone _____ Specialty _____
--	--	--

Patient		Partner	
Name (Last, First, Middle Initial)		Name (Last, First, Middle Initial)	
Address		Address	
City/State/Zip		City/State/Zip	
Social Security No.	Cell Phone	Social Security No.	Cell Phone
Home Phone	Work Phone	Home Phone	Work Phone
Date of Birth	Age	Date of Birth	Age
Marital Status	Marriage Date	Marital Status	Marriage Date
Patient's Employment		Partner's Employment	
Company Name	Occupation	Company Name	Occupation
Address		Address	
City/State/Zip		City/State/Zip	
Patient's Primary Insurance		Partner's Primary Insurance	
Insurance Company Name		Insurance Company Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Policy Holder Name		Policy Holder Name	
Policy No.	Group No.	Policy No.	Group No.
Emergency Contact			
Name	Day Phone	Night Phone	Relationship
Authorizations			
<p>AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay no-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s). I will pay you all costs of collection, including attorney's fees, up to the maximum permitted under applicable law, and other charges, if incurred.</p> <p>AUTHORIZATION TO RELEASE INFORMATION: I Hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.</p>			
Patient		Partner	
Signed (Patient or Parent if Minor)		Signed (Patient or Parent if Minor)	