

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: (____) _____ - _____ Email: _____
Date of Birth: ____/____/____ Age: _____ SSN: _____
Ethnicity: Hispanic/Latino or Non Hispanic/Non Latino Language: _____
Race: _____ Sex: M _____ F _____
Preferred Contact Method: _____

INSURANCE INFORMATION:(ALL information must be completed if applicable)

Primary Ins: _____ Policy # _____ PCP: _____
*Policyholder: _____ *Date of Birth: _____
Other Insurance: _____ Policy # _____
*Policyholder: _____ *Date of Birth: _____
Address of Policyholder if different: _____
City: _____ State: _____ Zip: _____ Phone: _____

LIST SIBLINGS:

PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER'S NAME:

Address: _____ City: _____
State: _____ Zip: _____ Home # (____) _____ - _____ Work # (____) _____
Date of Birth: ____/____/____ SSN: _____
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____

PARENT/LEGAL GUARDIAN INFORMATION:

FATHER'S NAME:

Address: _____ City: _____
State: _____ Zip: _____ Home # (____) _____ - _____ Work # (____) _____
Date of Birth: ____/____/____ SSN: _____
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO
PROCESS ANY CLAIMS FILED ON MY BEHALF. I AUTHORIZE PAYMENT OF MEDICAL
BENEFITS TO THE PHYSICIAN PROVIDING SERVICES.

SIGNATURE: _____ DATE: ____/____/____

THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND I HAVE GIVEN
ALL INSURANCE INFORMATION AND I TAKE FULL RESPONSIBILITY FOR ANY
CHARGES INCURRED THAT ARE NOT PAID/COVERED BY MY INSURANCE OR THAT
ARE RECOUPED DUE TO INSURANCE INFORMATION NOT PROVIDED.

SIGNATURE: _____ DATE: ____/____/____