REGISTRATION FORM

PATIENT INFORMATION

PHYSICIAN NAME	OFFICE NAME/LOCATION	PRIMARY CARE PHYSICIAN

Patient First Name	Middle Name	Last Name	SSN
			- -

Sex	Date Of Birth	Aliases	Marital Status
❒ MALE ❒FEMALE			❒Married ❒Widowed ❒Single ❒Divorced ❒Other

Permanent Address	Home Phone Number	Check preferred contact number
		❒
City	Work Phone Number	
		❒
State / Zip	Mobile Phone Number	
		❒
Emergency Contact Name / Relationship to Patient	Em. Contact Home Phone	Check preferred contact number
		❒
Address	Work Phone Number	
		❒
City / State / Zip	Mobile Phone Number	
		❒

GUARANTOR

Responsible Party	Guarantor First Name	Middle Name	Last Name
❒Self ❒Spouse ❒Father ❒Mother ❒Other			

Guarantor Sex	Guarantor Date of Birth	Guarantor Home Phone Number	Guarantor SSN
❒ MALE ❒FEMALE			- -

Guarantor Employer Address	Guarantor Employment Status	Guarantor Work Phone Number

City / State / Zip	Guarantor Employer Name

Primary Insurance

Primary Insurance Name	Date Effective From	Primary Insurance Address	
Patient Relationship to Subscriber ❒Self ❒Spouse ❒Child ❒Other	Insurance Phone Number	Subscriber/Insurance ID Number	Group Number
Name of Subscriber	Date of Birth	Employer Name	

Employer Status ❒Full Time ❒Part Time ❒Not Employed ❒Self-Employed ❒Retired ❒Active Military Duty ❒Student-Full Time ❒Student- Part Time ❒ Other

Covered Through	Employer Size	Copay Amount
❒Employment ❒Retirement ❒COBRA ❒Other	❒1-19 ❒20-99 ❒100+	

Secondary Insurance

Secondary Insurance Name	Date Effective From	Secondary Insurance Address	
Patient Relationship to Subscriber ❒Self ❒Spouse ❒Child ❒Other	Insurance Phone Number	Subscriber/Insurance ID Number	Group Number
Name of Subscriber	Date of Birth	Employer Name	

Employer Status ❒Full Time ❒Part Time ❒Not Employed ❒Self-Employed ❒Retired ❒Active Military Duty ❒Student-Full Time ❒Student- Part Time ❒ Other

Covered Through	Employer Size	Copay Amount
❒Employment ❒Retirement ❒COBRA ❒Other	❒1-19 ❒20-99 ❒100+	

Injury

Is this related to a motor vehicle accident?	Did this injury occur at work?
❒Yes ❒No	❒Yes ❒No

Authorization/ Releas

I authorize the physician/physician group above to provide treatment and or tests to me. In signing this agreement, I certify that the above stated facts are correct. I/We hereby assign and authorize payment of all insurance benefits directly to the physician/physician group above. I/We hereby authorize the physician/physician group above to furnish information from the patient's medical records to insurers, compensation carriers, healthcare facilities, or other agencies which may be providing financial assistance for the patient's care. I understand that i am financially responsible for any balance not covered by insurance.

_____/ _____/ _____
Date

X _____
Signature of Insured or Authorized Person