

PATIENT REGISTRATION FORM

Patient Account Number _____

Date _____

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____

Address _____ City _____ State ___ Zip _____

Telephone _____ Cell _____ Social Security _____

Employer _____ Phone _____ Referring Doctor _____

Married _____ Single _____

Emergency Contact _____ Phone _____

Reason for Visit Today _____

E-Mail Address: _____

RESPONSIBLE PARTY INFORMATION

**Please complete the information below if the person responsible for paying the bill is not the PATIENT.*

Responsible Party Name _____ Date of Birth _____

Address _____ City _____ State ___ Zip _____

Telephone _____ Social Security _____

Employer Name _____ Telephone _____

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, private, and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Consultation fee is \$50.00.

I agree to the assignments and financial responsibilities shown on this form. You should read those terms carefully.

X _____
SIGNED (Patient, or parent if under 18 years of age)

Date _____