

DATE		PATIENT REGISTRATION			FOR INTERNAL USE ONLY PATIENT NUMBER	
PATIENT INFORMATION						
SOCIAL SECURITY #			HOME ADDRESS			
FIRST NAME		MIDDLE				
LAST NAME			CITY	STATE	ZIP	
SEX	DATE OF BIRTH		EMAIL			
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED (CHECK ONE) <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> OTHER			HOME/CELL PHONE			
			WORK PHONE			
			REFERRING PHYSICIAN			
			HOW DID YOU HEAR OF US?			
EMPLOYER						
INSURANCE INFORMATION						
PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST						
<input type="checkbox"/> COMMERCIAL <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER						
INSURANCE COMPANY						
INSURED / CARD HOLDER'S NAME				RELATIONSHIP		
POLICY #		GROUP#		PHONE		
SECONDARY INSURANCE INFORMATION						
<input type="checkbox"/> COMMERCIAL <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER						
INSURANCE COMPANY						
INSURED / CARD HOLDER'S NAME				RELATIONSHIP		
POLICY #		GROUP#		PHONE		
EMERGENCY CONTACT						
SOCIAL SECURITY #			SEX			
FIRST NAME		MIDDLE		HOME PHONE		
LAST NAME			WORK PHONE			
SPOUSE / GUARANTOR / RESPONSIBLE PARTY						
SOCIAL SECURITY #			SEX	DATE OF BIRTH		
RELATIONSHIP			DAYTIME PHONE			
FIRST NAME		MIDDLE		EMPLOYER		
LAST NAME			ADDRESS			
ADDRESS			CITY	STATE	ZIP	
CITY	STATE	ZIP				
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/her services as described, realizing I am responsible to pay non-covered services.				SIGNATURE (Patient or Parent if Minor) Date		
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.				SIGNATURE (Patient or Parent if Minor) Date		