# Patient Registration Form

Name: _____
First Middle Last

Prefer to be called: _____

Address: _____
Street# Street Name Apt.#

_____
City State Zip

Employer: _____
Name Address

Home Phone: _____ Date of Birth. ____/____/____
Month Day Year

Work Phone: _____ Cell Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Social Security Number: _____ Sex: ☐ M ☐ F

Who Referred You? _____

Name of policy owner if other than patient: _____

Policy Holder Social Security Number: _____ Date of Birth: ____/____/____

Patient relationship to policy owner: ☐ Self ☐ Child ☐ Other: _____

***Please present insurance cards and photo ID to the receptionist so copies may be made.***

Do we have your permission to

Leave a message (appt. reminder, medical info) on your answering machine at home? ☐ YES ☐ NO

Leave a message at your place of employment? ☐ YES ☐ NO

Discuss your medical condition with any member of your household? ☐ YES ☐ NO

If yes, with whom: _____ Relationship: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, please ask our staff if you have any questions. Payment is expected from you at the time of service for "your part" of the charges, which may include payment for today's visit if your deductible has not been met. It is your responsibility to determine if the physician is considered to be a covered provider by your insurance plan, and you will be responsible for any "covered" and "non-covered" charges incurred by your visit. Your signature below indicates that you understand and accept this policy, that you authorize payment of medical benefits to the Doctor when an assigned claim is filed, and that you have had the opportunity to review or request the HIPAA Notice of Privacy Practices.

_____ _____
Signature of patient or legal guardian Date