PATIENT REGISTRATION

VERY IMPORTANT:

DO NOT TAKE ANY ANTIHISTAMINES SEVEN (7) DAYS PRIOR TO YOUR APPOINTMENT

PATIENT INFORMATION

***Bring this form to your appointment.**

Date:	D.O.B.:	Age:	
PATIENT NAME			
Last:	First:	Middle Initial:	
Sex: Male Female	Marital Status: Single Married Other		
Address:			
Home Phone:		Work Phone:	
Employer:		Occupation:	
Primary Care Physician:		Referred by:	
Have you or a family member been treated in this office before ? Yes No Name:			

RESPONSIBLE PARTY

(GUARANTOR/ INSURANCE POLICY HOLDER)

POLICY HOLDER INFORMATION			
Last:	First:	Middle Initial:	
D.O.B.:			
Relationship to Patient:		Marital Status: Single Married Other	
Address:			
Home Phone:		Work Phone:	
Employer:		Address:	

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Relationship to Patient:
Home Phone:	Work Phone:

INSURANCE INFORMATION

(or provide a copy of your insurance card)

Primary Insurance:	Secondary Insurance:
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birthdate:	Insured's Birthdate:
Insured's S.S. #:	Insured's S.S. #:
Employer:	Employer:
ID#:	ID#:
Group#:	Group#:
Ins. Co. Address:	Ins. Co. Address:
Effective Dates From: To:	Effective Dates From: To:
Does your Managed Care or insurance plan require a referral? Yes No	

AUTHORIZED, RELEASE, & CONSENT

Authorization to release information: I authorize the physician to release any information aquired in the course of my or my child's treatment to third party payors and/or other health care practitioners.

Authorization to pay benefits to physician: I authorize payment directly to the physician surgical or medical benefits, if any, otherwise payable to me for his/her services as described, and agree to pay for non-covered services.

Responsibility for payment of rejected services: I understand that my managed care company may require prior authorized or a primary care for referral for treatment in this office. If I do not obtain the required authorization or referral, I agree to be responsible for payment of services rendered on my or my dependent's behalf.

Authorization to treat a minor (under age 18): In the event of an emergency, and I cannot be contacted, I give permission to the doctors, or the persons under their instruction, to treat my child in their office or hospital as required by the events of that emergency situation.

X _____ **Date:** _____

Signature of patient or parent if a minor