PATIENT REGISTRATION

VERY IMPORTANT:

Do not take any antihistamines seven (7) days prior to your appointment

PATIENT INFORMATION

Date:	DOB:	Age:	
PATIENT NAME			
Last:		First:	Middle Initial:
Sex: male ☐	female ☐	Marital Status: Single ☐	Married ☐ Other ☐
Address:			
Town/City:		State:	Zip Code:
Home Phone:		Work Phone:	
Employer:		Occupation:	
Primary Care Dr.		Referred By:	
Have you or a family member been treated in this office before?	No ☐ Yes ☐	Name:	

RESPONSIBLE PARTY (GUARANTOR/INSURANCE POLICY HOLDER)

POLICY HOLDER INFORMATION			
Last:		First:	Middle Initial:
DOB:		Soc. Sec.#	
Relationship to Patient:		Marital Status: Single ☐	Married ☐ Other ☐
Address:			
Town/City:		State:	Zip Code:
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 of Patient:		Relationship of 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 acquired 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.

Signature of patient or parent if minor_____ Date_____