REGISTRATION FORM

PATIENT_____ PHONE (_____)_____
LAST NAME FIRST NAME MI

ADDRESS_____

CITY_____ STATE_____ ZIP_____ SOCIAL SECURITY #_____

SEX *M F* AGE_____ DATE OF BIRTH_____/_____/_____ MARITAL STATUS S M D W

PATIENT EMPLOYED BY_____ PHONE (_____)_____

ADDRESS_____ OCCUPATION_____

PRIMARY INSURANCE_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

ID #_____ SOCIAL SECURITY #_____ GROUP #_____ DATE OF BIRTH____/____/____

EMPLOYED BY_____ PHONE (_____)_____

ADDRESS_____ OCCUPATION_____

SECONDARY INSURANCE_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

ID #_____ SOCIAL SECURITY #_____ GROUP #_____ DATE OF BIRTH____/____/____

EMPLOYED BY_____ PHONE (_____)_____

ADDRESS_____ OCCUPATION_____

IN CASE OF EMERGENCY NOTIFY_____ PHONE (_____)_____

REFERRING DOCTOR_____ PHONE (_____)_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I am bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance carrier to pay and hereby assign directly to _____. all benefits, if any, otherwise payable for his services as described on the claim forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by me and paid to _____ will be charged to my account, in accordance with the above said assignment. I hereby agree and understand that if I receive payment from my insurance company for services rendered by _____., I am to endorse the check and mail the statement to his office. I clearly understand that it is still my responsibility to make sure the bill is paid in full at a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I acknowledge and understand the fact that if for some reason I fail to submit payment on my account and my account is being reported to a collection agency, a collection fee of 20 dollars and the balance will be added to my account.

PATIENT'S SIGNATURE_____ DATE_____/_____/_____