NEW PATIENT REGISTRATION FORM (Please Print)

Today's date:	Primary Care Practitioner/Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐M ☐F

Street address:			Social Security:	Home phone :
City:	State:	ZIP Code:	Email:	Cell phone :
Occupation:	Employer:			Employer phone:

Were you referred to our Office? ☐ Yes ☐No If yes, by whom?

(*Mark all that apply*) **You may leave voice mail *appointment reminders* at:** *Home:* ☐ *Work*: ☐ *Cell:* ☐

You may send *general information* and *appointment reminders* to my Email noted above: ☐	**You may share *general information* with the following person:** (relationship)

INSURANCE INFORMATION

(*Please show your insurance card and photo identification to the receptionist*)

Person responsible for bill:	Birth date:	Address (if different from above):	Home phone:

Occupation:	Employer:	Employer address:	Employer phone:

Is this patient covered by insurance? ☐ Yes ☐ No	Other Program (such as Workers Comp):

Subscriber's name:	Subscriber's S.S.:	Birth date:	Group number:	Policy number:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group number:	Policy number:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other ____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Cell phone:

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefit program to release information to you regarding my coverage.
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to you.
4. I understand and **authorize release** of all health information about me to my insurer, health plan, employer program or similar benefit program identified above **to obtain payment** for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

_______________________________________ _______________________
Patient/Guardian signature *Date*