

FAMILY PRACTICE REGISTRATION

PATIENT INFORMATION					
NAME		SS#		TDL#	
ADDRESS					
CITY		STATE		ZIP	
HOME #		CELL #		EMAIL:	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE	DOB	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		
PATIENT EMPLOYED BY				OCCUPATION	
BUSINESS ADDRESS				BUS PHONE ()	
WHO MAY WE THANK FOR REFERRING YOU?					
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED:				PHONE ()	
PRIMARY INSURANCE					
PERSON RESPONSIBLE FOR ACCOUNT (LAST, FIRST, MI)					
RELATION TO PATIENT			DOB		SS#
ADDRESS (IF DIFFERENT FROM PATIENT'S)				PHONE ()	
CITY		STATE		ZIP	
PERSON RESPONSIBLE EMPLOYED BY				OCCUPATION	
BUSINESS ADDRESS				BUS PHONE ()	
INSURANCE COMPANY					
ID# / SUBSCRIBER#			GROUP#		
NAMES OF OTHER DEPENDENTS COVERED UNDER THIS PLAN					
ADDITIONAL INSURANCE					
IS PATIENT COVERED BY ADDITIONAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO					
SUBSCRIBER NAME		RELATION TO PATIENT		DOB	
ADDRESS (IF DIFFERENT FROM PATIENT'S)				PHONE ()	
CITY		STATE		ZIP	
SUBSCRIBER EMPLOYED BY				BUS PHONE ()	
INSURANCE COMPANY				SS#	
ID# / SUBSCRIBER#			GROUP#		
NAMES OF OTHER DEPENDENTS COVERED UNDER THIS PLAN					
ASSIGNMENT AND RELEASE					
<p>I, the undersigned, certify that I (or my dependent) have insurance coverage with (NAME OF INSURANCE COMPANY(IES)) _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I, the patient give consent for treatment.</p>					
RESPONSIBLE PARTY SIGNATURE		RELATIONSHIP		DATE	