FAMILY PRACTICE
REGISTRATION

PATIENT INFORMATION

NAME	SS#	TDL#
ADDRESS		
CITY	STATE	ZIP
HOME #	CELL #	EMAIL:

SEX ☐ M ☐ F	AGE	DOB	*MARITAL STATUS:* ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYED BY	OCCUPATION
BUSINESS ADDRESS	BUS PHONE ( )
WHO MAY WE THANK FOR REFERRING YOU?	DOCTOR CHOSEN:
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? ☐ YES ☐ 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

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.

_______________________________________ _________________________________ ______________________

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE