

Patient Registration (Insurance)

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____

Home Phone _____

Work Phone _____

Social Security # _____

Age _____ Birthdate _____ Sex M/ F

Single/Married/Widowed/Separated/Divorced

Driver's License # _____ State _____

Employed By _____

School Name _____

Insured (Responsible party) if Different from Above.

Relationship to the patient?

Spouse () Parent () Other ()

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Social Security # _____

Age _____ Birthdate _____ Sex M/F

Single/Married/Widowed/Separated/Divorced

Driver's License # _____ State _____

Employed By _____

Primary Insurance Information:

Insurance Co. _____

Policy I.D. Number _____

Group Number _____

Effective Date _____

Plan Phone Number _____

Is there a second insurance to bill? Yes/No

Secondary Insurance Information

Insurance Co. _____

Policy I.D. Number _____

Group Number _____

Effective Date _____

Plan Phone Number _____

Referring Doctor _____

Pharmacy _____
Race _____
Ethnicity _____
Preferred Language _____
Email _____
County that you Live in _____

I hereby authorize the doctor to release all information necessary to my insurance company to process all claims incurred and to send all benefits directly to this office.

Signatur

Signature: _____

Date: _____