REGISTRATION (Please Print) Date: ____________________

Phone: Home ______________________ Cell ___________________________ Work ____________________________

Patient: ____
Last Name First Name

Responsible Party (if a minor) ____

Street Address: ____

City ____ State ________________ Zip _________________________

Sex: ☐ M ☐ F Age: ___________ Birthdate _________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated /Divorced

Patient's Employer ____ Occupation ___________________________

Employer Address ____

Spouse Name ____Birthdate ______________________________

Business Name and Address ____

Occupation ____ Business Phone _________________________

Responsible Party for this account? ____________________________ Relationship ___________________________

Social Security#: Patient ____________________________ Spouse ____

Do you have medical insurance? ☐ No ☐ Yes If yes: Primary Insurer Name _______________________________

Contract # ___________________ Group# ______________________ Subscriber# ____________________________

Name of Secondary Insurer (if any) ____

Contract # ___________________ Group# ______________________ Subscriber# ____________________________

☐ Medicare Claim ID# ____

If on Welfare, your number ____ County of ____________________________

In case of emergency, notify: _______________________________________ Phone _______________________________

How did you learn of our practice? ____

I, the undersigned, have insurance coverage with ____ and assign directly to

Dr. __________________________ all medical benefits. If any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize __________________ to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions

____ Date ____________________________
Signature of Insured/Guardian

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ______________________ for any services furnished me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I, the undersigned signature, request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicted in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the determinatiion of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ____ Date _______________________