PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex Age
Mother		Marital Status	
Mother's Social Security Number	Driver's License No. & State	D.O.B.	
Home Address	City	State	ZIP
Mailing Address if Different	City	State	ZIP
Home Telephone	Work Telephone	Cell Phone	
Occupation	Employer's Name		
Employer's Address	City	State	ZIP
Father's Name	Social Security Number		D.O.B.
Occupation	Employer's Name		Work #
NOTIFY IN CASE OF EMERGENCY			
Name	Relationship		
Home Telephone	Work Telephone	Cell Phone	
GUARANTOR			
Name	Telephone		
Address	City	State	ZIP
Insurance Company	Claim Address		
Subscriber's Name	Subscriber's D.O.B.	Subscriber's Social Security Number	
Insurance ID Number	Group Number		
Secondary Insurance	Claim Address		
Subscriber's Name	Subscriber's D.O.B.	Subscriber's Social Security Number	
2nd Insurance ID Number	Group Number		

I authorize payment to the above physician of the benefits otherwise payable to me. In addition, it is understood by signing this sheet that any collections costs incurred in receiving payment in full for services rendered will be borne by the signor. The costs will be added to the bill at the time collection procedures are instituted and will be the maximum allowable by law.

SIGNATURE_____ DATE_____