

PATIENT REGISTRATION FORM

Today's Date ____/____/____

Name _____
Last First MI

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

SSN _____

Mailing Address _____
City State Zip Code

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Employer _____ / Occupation _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First MI

Address _____
City State Zip Code

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Date of Birth ____/____/____ Sex ____ SSN _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance

Name of Policy Holder _____

DOB ____/____/____

Relationship of patient to Policy Holder _____

Secondary Insurance

Name of Policy Holder _____

DOB ____/____/____

Relationship of patient to Policy Holder _____

In Case of emergency, person to contact _____

Address _____ Phone (____) _____

Referring Doctor _____

How may we contact you regarding follow-up, labs or biopsy results, etc.?

Send a message via e-mail? (This includes normal lab results) ☐ YES ☐ NO E-mail: _____

May we call you and leave a message
at home or on your cell phone? ☐ YES ☐ NO _____

Discuss your medical condition with
any other person?..... ☐ YES ☐ NO

If yes, whom _____ Relationship _____

We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____