PATIENT REGISTRATION SHEET

Patient (Mr. Mrs.)
Name: (Miss Ms.) _____ Date _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ E-Mail Address: _____

Sex: M F Martial Status: Single Divorced Married Widowed

Social Security Number: _____ Date of Birth _____/_____/_____

Spouse Name: _____

Name of Emergency Contact: _____ Phone #:_____

Patient's Family Physician: _____ Phone #:_____

Referred By: _____ Phone #:_____

Allergies: _____

Employed By: _____

Address: _____

_____

Occupation: _____

Send Bill To: _____ Patient _____ Employer _____ Relative _____ Other

Address: _____

Insurance: 1. _____ Medicare #: _____

2. _____ Policy #: _____

3. _____ Policy #: _____

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR PAYMENT IN FULL OF ALL ACCOUNTS WITH THE EXCEPTION OF INDUSTRIAL INJURIES, MEDICARE/MEDI-CAL. I HEREBY AUTHORIZE THE ABOVE DOCTORS TO RELEASE RECORDS BOTH MEDICAL AND INSURANCE TO OTHER DOCTORS OR LEGITIMATE REQUESTING SOURCE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ABOVE PHYSICIANS OR SUPPLIER OF SERVICES DESCRIBED.

A PHOTOCOPY OF THIS AUTHORIZATION AND ASSIGNMENT OF BENEFITS SHALL BE AS VALID AS THE ORIGINAL.

Signed _____ Date: _____