

PATIENT REGISTRATION

OFFICE USE ONLY

PCN _____ DR# _____

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DX: _____ FEE \$ _____ W/O \$ _____

Please Print

PATIENT INFORMATION

Please Complete Entire Section

PATIENT: _____ DATE OF BIRTH: ____/____/____ SEX: M ☐ F ☐
(Last Name) (First Name) (Middle Initial) (Month) (Day) (Year) (Male) (Female)

ADDRESS: _____
(Number) (Street) (Apt #) (City) (State) (Zip Code) (Area Code) (Number)

SOCIAL SECURITY#: ____/____/____ OCCUPATION: _____ MARITAL STATUS: ☐ ☐ ☐ ☐
(Married) (Single) (Divorced) (Widowed)

EMPLOYER INFORMATION: _____
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

FAMILY PHYSICIAN: _____
(Last) (First) (Area Code) (Number)

PATIENT WAS REFERRED/AUTHORIZED BY: _____
(Area Code) (Number)

Please Complete Entire Section

RESPONSIBLE PARTY

Please Print

RELATIONSHIP TO PATIENT: (Please check the appropriate box) SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

GUARANTOR: _____ SOCIAL SECURITY#: ____/____/____
(Last Name) (First Name) (Middle Initial)

ADDRESS: _____
(Number) (Street) (Apt #) (City) (State) (Zip Code) (Area Code) (Number)

EMPLOYER INFORMATION: _____
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

Please Complete Entire Section

INSURANCE INFORMATION

Please Print

PRIMARY INSURANCE: _____
(Area Code) (Number)

INSURED'S NAME: _____ RELATION TO PATIENT: ☐ ☐ ☐ ☐
(Last) (First) (Middle Initial) (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ____/____/____ INSURED'S SS#: ____/____/____ GROUP/PLAN#: _____
(Month) (Day) (Year)

EMPLOYER INFORMATION: _____
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

SECONDARY INSURANCE: _____
(Area Code) (Number)

INSURED'S NAME: _____ RELATION TO PATIENT: ☐ ☐ ☐ ☐
(Last) (First) (Middle Initial) (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ____/____/____ INSURED'S SS#: ____/____/____ GROUP/PLAN#: _____
(Month) (Day) (Year)

EMPLOYER INFORMATION: _____
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

Required Section

ASSIGNMENT OF BENEFITS / TREATMENT AUTHORIZATION AND RELEASE

NAME OF DOCTOR/THERAPIST(PROVIDER): _____

I hereby authorize treatment of the above mentioned PATIENT and further authorize PROVIDER to release such information including diagnosis to my referring physician as well as that which may be required to process any insurance claims covering my treatment. In addition, I hereby authorize direct payment, to the above named provider, the benefits to which I may be entitled by my insurance carrier. I also understand that I am **RESPONSIBLE** for any **OUTSTANDING BALANCE DUE** on my account.

I understand that the above mentioned PROVIDER must receive 24 hours notice of cancellation for any appointments which have been scheduled. If you fail to notify the above mentioned provider before the 24 hour period you may be charged up to the full professional fee.

Signature _____ Date _____