

**PATIENT REGISTRATION**

Patient Name	
Birthdate	Sex M F
Address	
City	Zip
Home Phone	Cell Phone
Work Phone	E Mail
Social Security No.	Marital Status S M
Referred by	

Emergency Contact	Phone
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**FOR PATIENTS COVERED BY INSURANCE**

**Primary Insurance:**

Subscriber's Name	
Subscriber's Birthdate	
Subscriber Social Security No.	
Subscriber's Employer	Group No.

**Secondary Insurance:**

Subscriber's Name	
Subscriber's Birthdate	
Subscriber Social Security No.	
Subscriber's Employer	Group No.

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I understand that I am responsible for payment regardless of insurance coverage, and that finance charges will be applied to balances over 60 days. Credit bureau reports may be obtained.

I have received a copy of the Notice of Privacy Practices, and consent to your uses of my protected health information.

Signature of Patient or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_