Patient Registration Form

Is today's visit work related?
If yes, do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? ☐ Yes ☐ No How did you hear about us? _____

What's the reason for your visit today? _____

PATIENT INFORMATION

Name: ☐ Male ☐ Female
Date of Birth: SS#:
Mailing Address: Apt#:
City: State: Zip:
Home Ph#: Cell Ph#:
*Confidential Phone:
Home Email:
*Confidential Email:

Primary Care Physician (PCP):
PCP Address:
PCP Ph#:
Preferred Pharmacy:
Pharmacy Ph#:
Sexual Orientation:
Gender ID:

For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:
Relationship:
Home Ph#:
Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:
Race: ☐ I prefer not to answer
Ethnicity: ☐ I prefer not to answer
Best Form of Contact: ☐ Cell ☐ Home ☐ Email ☐ Mail
Best Time to Call: May we leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Ins: Ins #:
Name of Insured:
Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:
Name of Insured:
Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female
Date of Birth: SS#:

Relationship:
Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I also agree and understand that I am financially responsible and will be billed by the outside lab or supply vendor for any charges that may occur when sending labs to an outside facility or for receiving DME supplies during my visit. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature Date

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature Date