

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES CLEARLY

PATIENT NAME		ADDRESS			
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMAIL ADDRESS		PATIENT EMPLOYER		EMPLOYER PHONE	
INSURED/RESPONSIBLE PARTY INFORMATION			RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian		
NAME		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR (Optional):			REFERRING DOCTOR (Optional):		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE
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Authorization to release health information to Spouse, Parent, Significant other etc.:			
Name(s)		ADDRESS	
CITY, STATE		ZIP	HOME PHONE
DATES OF SERVICE		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)	
FROM:	TO:	<input type="checkbox"/> NEVER DATE:	
Release the following information:			
<input type="checkbox"/> All Records	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Operative Reports <input type="checkbox"/> History & Physicals

RELEASE OF INFORMATION	
I understand that:	
<ul style="list-style-type: none"> once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). my records are protected and cannot be disclosed without written permission this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department. 	
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

