

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last -- First -- Middle Initial)		Address		
City, State		Zip	Home Phone	Work Phone
Patient Birth Date	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 Employer Name	Patient Employer Address (Street Address -- City, State, Zip)		Employer Phone	

RESPONSIBLE PARTY INFORMATION		RELATIONSHIP TO PATIENT: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
Name (First -- Last -- Middle Initial)		Address (if different from patient)		
Home Phone	Work Phone	SSN	Birth Date	Employer

INSURANCE INFORMATION				
Primary Insurance Name	ID Number	Employer Name and Phone		
Subscriber Name	DOB	SSN	Relationship to Patient	
Secondary Insurance Name	ID Number	Employer Name and Phone		
Subscriber Name	DOB	SSN	Relationship to Patient	
In Case of Emergency Contact	Relationship	Phone Number		

Who Can We Thank for Your Visit/How Did You Hear About Us:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I hereby acknowledge that I am financially responsible and hereby agree to pay for all non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If I do not pay my accounts in full, I hereby agree to pay all costs of collection, including collection agency fees and attorney's fees.

Signature (Patient or, if minor Signature of parent or guardian)	Date
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RELEASE OF INFORMATION

I understand that:

- 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 (1) year, unless I provide a written notice of revocation to the Medical Records Department.
- I hereby authorize the following person(s) to receive the following information:

NAME	RELATIONSHIP TO PATIENT	AUTHORIZED TO RELEASE:		
		<input type="checkbox"/> All Records <u>OR</u> <input type="checkbox"/> Provider Notes	<input type="checkbox"/> Verbal Updates <input type="checkbox"/> Billing Records	<input type="checkbox"/> Prescriptions
		<input type="checkbox"/> All Records <u>OR</u> <input type="checkbox"/> Provider Notes	<input type="checkbox"/> Verbal Updates <input type="checkbox"/> Billing Records	<input type="checkbox"/> Prescriptions
		<input type="checkbox"/> All Records <u>OR</u> <input type="checkbox"/> Provider Notes	<input type="checkbox"/> Verbal Updates <input type="checkbox"/> Billing Records	<input type="checkbox"/> Prescriptions
		<input type="checkbox"/> All Records <u>OR</u> <input type="checkbox"/> Provider Notes	<input type="checkbox"/> Verbal Updates <input type="checkbox"/> Billing Records	<input type="checkbox"/> Prescriptions

Signature of Patient or Legal Representative	Date
If signed by legal representative, relationship to Patient	Signature of Witness (Optional)