# NEW PATIENT REGISTRATION

TODAY'S DATE  /  /

PLEASE PRINT

## PATIENT INFORMATION

| LAST NAME | FIRST | MI | ADDRESS |
|---|---|---|---|
| | | | |

| CITY | STATE | ZIP CODE | SEX | ADDRESS |
|---|---|---|---|---|
| | | | | |

| EMPLOYED | EMPLOYER/SCHOOL | HOME PHONE | WORK PHONE |
|---|---|---|---|
| YES ☐ NO ☐ | | ( ) - | ( ) - |

| DATE OF BIRTH | SOCIAL SECURITY # | PATIENT ID # | MARITAL STATUS |
|---|---|---|---|
| / / | — — | | SINGLE ☐ MARRIED ☐ OTHER ☐ |

## RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

| RESPONSIBLE PARTY SIGNATURE | TODAY'S DATE |
|---|---|
| X | / / |

## REFERRED BY - CHECK HERE IF REFERRED BY DOCTOR ☐

| LAST NAME | FIRST | MI | ADDRESS | TELEPHONE |
|---|---|---|---|---|
| | | | | ( ) - |

## IN CASE OF EMERGENCY CALL

| LAST NAME | FIRST NAME | MI |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| HOME PHONE | WORK PHONE |
|---|---|
| | |

RELATIONSHIP

## PRIMARY INSURANCE COMPANY INFORMATION

| PRIMARY INSURANCE COMPANY NAME | IDENTIFICATION NUMBER | GROUP NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE | PHONE |
|---|---|---|---|---|
| | | | | |

| SUBSCRIBER (if other than patient) | SEX | DATE OF BIRTH |
|---|---|---|
| | | / / |

| SOCIAL SECURITY NUMBER | PHONE NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

## SECONDARY INSURANCE COMPANY INFORMATION

| SECONDARY INSURANCE COMPANY NAME | IDENTIFICATION NUMBER | GROUP NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE | PHONE |
|---|---|---|---|---|
| | | | | |

| SUBSCRIBER (if other than patient) | SEX | DATE OF BIRTH |
|---|---|---|
| | | / / |

| SOCIAL SECURITY NUMBER | PHONE NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

REASON FOR TODAY'S VISIT - OR - CHIEF COMPLAINT

### PAYMENT OF BENEFITS

I authorize payment of benefits, as determined by the Company, directly to:

Surgeon/Physician/Dentist ☐ Yes ☐ No

I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.

X  DATE / /

### MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X  DATE / /

X  DATE / /

101M-1