
**PATIENT REGISTRATION 01/01/2016**

## PATIENT

**Patient Name** : _____ DOB___/___/_____

Address: _____ Phone#_____

City/State/Zip: _____ County_____ Cell #_____

Marital Status: S / M / D Sex: Male / Female Maiden Name:_____

Social Security #_____ Email Address: _____

## Responsible Party for Medical Expenses

__Parent ___Self ___Spouse *(if self go to insurance section)* Phone_____

Parent or Spouse's Name_____ DOB___/___/____ SS#_____

Address_____ Employer_____

## Medical Insurance Company

Primary Insurance: _____Group#_____ ID#_____

Date of Birth of Insured: __ /__ /___

Subscriber Name:_____ Covers: __Self __Family Effective Date:__/__/___

Secondary Insurance:_____ Group# _____ ID# _____

Subscriber Name:_____ Covers : __Self __Family Effective Date:__/__/___

Date of Birth of Insured: __ /__ /___

## Emergency Contact

Name:_____ Relationship: _____

Street:_____ Phone: _____

City/State/Zip:_____

## Authorization for Release of Information

Authorization is hereby granted to release to the above named Insurance Company. Such information may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to above said clinic.

Signature_____ Date:_____

**Who do we thank for referring you to us today? _____**

MT/TB