PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security # Date of Birth

First Name Middle Last Name

Home Address City State Zip

Email Address Race _____ Ethnicity _____

Gender (Circle as many as are appropriate)

Birth Sex: Male Female Transgender Other

Current Sex: Male Female Transgender Other

Marital Status (Circle One) Married Single Divorced Widowed

Home Phone ( )

Cell Phone ( )

(Circle One) Employed Retired Disabled F/T Student Other

Work Phone ( )

Employer Referring Physician

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance ID # GR #

Name of Insured DOB SS#

SECONDARY INSURANCE INFORMATION

Insurance ID# GR #

Name of the Insured DOB SS#

EMERGENCY CONTACT

Relationship

First Name Middle Last

Home Phone ( ) Work Phone ( ) Cell ( )

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security # Sex Date Of Birth

Relationship Daytime Phone ( )

First Name Middle Last Name

Address City State Zip

Employer Address

City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) DATE