REGISTRATION INFORMATION

(Please Print)

Date: Home Phone:

Cell Phone:

Patient:

Last Name First Name M.I.

Responsible Party (If a minor)

Street Address:

City: State: Zip:

Sex: □ M □F Age Birth Date Single Married Widowed Separated Divorced

Social Security # Driver's License #

Patient Employed By:

Business Address:

Occupation: Business Phone:

Purpose of Visit:

Spouse (or responsible party) Name:

Employed By:

Business Address:

Occupation: Business Phone:

Social Security # Driver's License #

Do you have Medical Insurance? □ No □Yes ► If yes,

Name of Primary Insurer

Subscriber # Group # Phone:

In case of emergency, who should be notified? Phone:

How did you learn of our practice?

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services Rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and That I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ______________________ hereby authorize ______________________ to pay and hereby assign directly to
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to ______________________ all benefits, if any, otherwise payable to me for
(Provider's Name)

his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge

that any insurance benefits, when received by and paid to ______________________ will be
(Provider's Name)

credited to my account, in accordance with the above said assignment.

______________________ ______________________
(Authorized Signature of Subscriber) (Date)