PATIENT REGISTRATION FORM

REGISTRATION DATE M D Y | UPDATED REGISTRATION

PRACTICE NAME (OFFICE USE ONLY)	PRACTICE NO.	PATIENT NO.	CROSS REFERENCE ID NO.

PERSONAL INFORMATION

PATIENT NAME (LAST) (FIRST) (MI)					OCCUPATION		
MAIDEN NAME (IF APPLICABLE)/OPTIONAL STREET ADDRESS					**EMPLOYER NAME**		
STREET ADDRESS (MAILING)					STREET ADDRESS		
CITY		STATE	ZIP CODE		CITY	STATE	ZIP CODE
HOME PHONE (INCLUDE AREA CODE)		BUSINESS PHONE (INCLUDE AREA CODE)			**CLOSEST RELATIVE**	RELATIONSHIP	
SEX M F	**DATE OF BIRTH** M D Y	**AGE**	**MARITAL STATUS** M S D W	**SOCIAL SECURITY NUMBER**	STREET ADDRESS		
GUARANTOR NAME (PERSON TO BILL IF OTHER THAN PATIENT)					CITY	STATE	ZIP CODE
STREET ADDRESS					HOME PHONE (INCLUDE AREA CODE)	BUSINESS PHONE (INCLUDE AREA CODE)	
CITY		STATE	ZIP CODE		**REFERRING PHYSICIAN** (LAST, FIRST, MI)	**UPIN #/PROVIDER#**	
HOME PHONE (INCLUDE AREA CODE)		BUSINESS PHONE (INCLUDE AREA CODE)			STREET ADDRESS		
PRIMARY CARE PHYSICIAN (LAST, FIRST, MI)			PROVIDER #		CITY	STATE	ZIP CODE
STREET ADDRESS					PHONE (INCLUDE AREA CODE)		
CITY		STATE	ZIP CODE				

HEALTH INSURANCE

HEALTH INSURANCE	SUBSCRIBER INFORMATION	IDENTIFICATION NO.	COPY OF INS. ID CARD ATTCHD
PRIMARY COMPANY NAME	SUBSCRIBER NAME	CERTIFICATE NO.	☐
ADDRESS	PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 / SPOUSE 2 / CHILD 3 / OTHER 4	GROUP NO. / NAME	
SECONDARY COMPANY NAME	SUBSCRIBER NAME	CERTIFICATE NO.	☐
ADDRESS	PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 / SPOUSE 2 / CHILD 3 / OTHER 4	GROUP NO. / NAME	
OTHER INS. COMPANY NAME	SUBSCRIBER NAME	CERTIFICATE NO.	☐
ADDRESS	PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 / SPOUSE 2 / CHILD 3 / OTHER 4	GROUP NO. / NAME	

INJURY

☐ WORKERS' COMP ☐ AUTO ACCIDENT ☐ OTHER	CLAIM NO.
INSURANCE COMPANY NAME	FILE NO.
ADDRESS	DATE OF INJURY

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries *or* carriers of insurance companies, any information needed for this or a related Medicare *or* insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **X** DATE / /