

PATIENT REGISTRATION SHEET (PLEASE PRINT)

DATE: _____

PATIENT INFORMATION		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	DATE OF BIRTH:	SSEX:
MARITAL STATUS:	SOCIAL SECURITY:	
EMPLOYER:	WORK PHONE:	CELL PHONE:
EMPLOYER ADDRESS:	CITY, STATE:	ZIP CODE:
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:	
PHARMACY NAME:	PHARMACY LOCATION:	

EMERGENCY CONTACT		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER ADDRESS:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)		
LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY, STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER ADDRESS:	

INSURANCE INFORMATION	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
POLICY NUMBER:	POLICY NUMBER:
DOB: SSN:	DOB: SSN:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:

Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future of this practice.

Guarantee of Payments: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33 and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice if required to collect my debt owed.

Signature of Responsible Party: _____ **Date:** _____