

# Patient Registration

Doctor: \_\_\_\_\_

Internal Patient ID #: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  Home  Work  Other

Phone: \_\_\_\_\_  Home  Work  Other

## PATIENT EMPLOYMENT

Employed  Retired  Other

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

## GUARANTOR- Responsible Party-who carries the Insurance

Same as Patient \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

## PRIMARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

## SECONDARY INSURANCE

Same as Patient  Same as Guarantor  Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Sex:  M  F

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

## CONTACTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## GUARANTOR'S EMPLOYMENT INFORMATION

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to the attending physician. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not said insurance company pays. I hereby authorize said assigned to release all information necessary to secure payment.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_