NEW PATIENT REGISTRATION **Please Print**

Last Name: _____ First Name: _____ MI: ___

Street Address, State, Zip: _____

Home # with area code: _____ Alt. # with area code: _____

Date of Birth: _____ Age: _____ SSN #: _____

Marital Status: Single _____ Married _____ Other_____ Male or Female: _____

Primary Insurance Co: _____

ID#: _____ Group#: _____

Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Male or Female: _____

Policy Holder's Phone#: _____ Relationship to Patient: _____

Secondary Insurance Co: _____

ID#: _____ Group#: _____

Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Male or Female: _____

Policy Holder's Phone#: _____ Relationship to Patient: _____

Employer Name: _____

Address/Phone#: _____

Emergency Contact: _____

Phone #: _____ Relationship to Patient: _____

Parent(s)/Guardian/POA Name: _____

Address/Phone#: _____

Guarantor Name (if under 18 years of age): _____

Date of Birth: _____ SSN#: _____

Address/Phone#: _____

Please read the following then sign:

Responsible Party Statement: As the responsible party, I agree that all charges that are not directly paid by my insurance company(ies) will be my responsibility.

Payment of Benefits: I authorize payment of benefits, as determined by the Company, directly to the physician: **Yes** ____ **No** ____
I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by my Insurance Company(ies) in the event that the charges made are not reasonable and customary.

Medical Release Authorization: ***Insured party must sign for all claims. Dependent patient must also sign if not a minor.***
I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regards to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

Notice of Privacy Practices: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPPA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

Patient/Parent/Guardian signature _____ Date: _____