PATIENT REGISTRATION

Date: _____

Type of Visit: ☐ Urgent Care – Chief Complaint/Symptoms: _____

☐ Worker's Compensation – Injury: _____

☐ K-12 Sports/School PE ☐ College - Adult Sports/School PE ☐ Wellness Exam

☐ Pre-Employment Physical ☐ DOT Medical Exam ☐ Drug Screening

☐ Other *(Please explain)* _____

Patient

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Sex: _____ Marital Status: _____

Address: _____ Primary Phone: _____

City: _____ Secondary Phone: _____

State: _____ Zip Code: _____

Would you like to receive emails from us? Y☐ N☐ Email Address: _____

Employer Name/Phone: _____

Race

☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino

Preferred Language: _____ Do You Need Translation: Y☐ N☐

Responsible Party

**Not Required if 18 or over*

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Sex: _____ Marital Status: _____ Relationship to Patient: _____

Address: _____ ☐ Home Phone: _____

City: _____ ☐ Cell Phone: _____

State: _____ Zip Code: _____ ☐ Work Phone: _____

Employer Name/Phone: _____

In Case of Emergency

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____ Primary Phone: _____

City: _____ Secondary Phone: _____

State: _____ Zip Code: _____ Relationship to Patient: _____

Health Insurance

Primary Insurance: _____

Member ID: _____

Group #: _____ Effective Date: ___/____/____

Policy Holder's Name: _____

Date of Birth: _____/_____/_____

SSN: _____/_____/_____

Employer: _____

Relationship to Patient: _____

Secondary Insurance: _____

Member ID: _____

Group #: _____ Effective Date: ___/___/___

Policy Holder's Name: _____

Date of Birth: _____/_____/_____

SSN: _____/_____/_____

Employer: _____

Relationship to Patient: _____

Please complete your registration on the back of this form

PATIENT REGISTRATION (Continued)

Primary Physician	Primary Care Physician: _____ City: _____ Phone: _____
Medications	Please list all medications (with their dosage) that you are currently taking, including over the counter: *If you carry a list with you, please allow the registrar to make a copy for our records.* _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Please list any allergies to medications you have: _____ _____ _____ _____ _____ _____

Who referred you to us: _____

How did you hear about us? □ Billboard □ Doctor □ Drive by □ Friend/Relative □ Internet/Web Page
□ Phone Book □ Radio □ Television □ Work □ Other _____

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice.
I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE *AND THAT* ***I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.***
In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Photocopy of this agreement shall be as valid as the original.

_____ _____
Signature Date