PATIENT REGISTRATION

OFFICE USE ONLY

PCN _____ DR# _____

CHECK ONE ☐ CA ☐ INS ☐ D/COV ☐ P/O ☐ HMO ☐ VW

DX:_____ FEE $ _____ W/O $ _____

Please Print **PATIENT INFORMATION** **Please Complete Entire Section**

PATIENT: _____ (Last Name) (First Name) (Middle Initial) DATE OF BIRTH: ____ / ____ / ____ (Month) (Day) (Year) SEX: M ☐ F ☐ (Male) (Female)

ADDRESS: _____ (Number) (Street) (Apt #) (City) _____ (State) (Zip Code) (Area Code) (____) _____ (Number)

SOCIAL SECURITY#: ____ / ____ / _____ OCCUPATION: _____ MARITAL STATUS: ☐ ☐ ☐ ☐ (Married) (Single) (Divorced) (Widowed)

EMPLOYER INFORMATION: _____ (Name) (Address) (City) (State) (Zip) (Area Code) (____) - _____ (Number)

FAMILY PHYSICIAN: _____ (Last) (First) (Area Code) (____) - _____ (Number)

PATIENT WAS REFERRED/AUTHORIZED BY: _____ (____) - _____ (Area Code) (Number)

Please Complete Entire Section **RESPONSIBLE PARTY** **Please Print**

RELATIONSHIP TO PATIENT: (Please check the appropriate box) SELF [ ] SPOUSE [ ] PARENT [ ] OTHER [ ]

GUARANTOR: _____ (Last Name) (First Name) (Middle Initial) SOCIAL SECURITY#: ____ / ____ / _____

ADDRESS: _____ (Number) (Street) (Apt #) (City) _____ (State) (Zip Code) (Area Code) (____) - _____ (Number)

EMPLOYER INFORMATION: _____ (Name) (Address) (City) (State) (Zip) (Area Code) (____) - _____ (Number)

Please Complete Entire Section **INSURANCE INFORMATION** **Please Print**

PRIMARY INSURANCE: _____ (Area Code) (____) - _____ (Number)

INSURED'S NAME: _____ (Last) (First) (Middle Initial) RELATION TO PATIENT: ☐ ☐ ☐ ☐ (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ____ / ____ / ____ (Month) (Day) (Year) INSURED'S SS# : ____ / ____ / _____ GROUP/PLAN# : _____

EMPLOYER INFORMATION: _____ (Name) (Address) (City) (State) (Zip) (Area Code) (____) - _____ (Number)

SECONDARY INSURANCE: _____ (Area Code) (____) - _____ (Number)

INSURED'S NAME: _____ (Last) (First) (Middle Initial) RELATION TO PATIENT: ☐ ☐ ☐ ☐ (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ____ / ____ / ____ (Month) (Day) (Year) INSURED'S SS# : ____ / ____ / _____ GROUP/PLAN# : _____

EMPLOYER INFORMATION: _____ (Name) (Address) (City) (State) (Zip) (Area Code) (____) - _____ (Number)

Required Section **ASSIGNMENT OF BENEFITS / TREATMENT AUTHORIZATION AND RELEASE**

NAME OF DOCTOR/THERAPIST(PROVIDER): _____

I hereby authorize treatment of the above mentioned PATIENT and further authorize PROVIDER to release such information including diagnosis to my referring physician as well as that which may be required to process any insurance claims covering my treatment. In addition, I hereby authorize direct payment, to the above named provider, the benefits to which I may be entitled by my insurance carrier. I also understand that I am **RESPONSIBLE** for any **OUTSTANDING BALANCE DUE** on my account.

I understand that the above mentioned PROVIDER must receive 24 hours notice of cancellation for any appointments which have been scheduled. If you fail to notify the above mentioned provider before the 24 hour period you may be charged up to the full professional fee.

Signature_____ **Date**_____