



**PATIENT REGISTRATION FORM**

**Patient Information:**

Name (Last, First)	Age	Date of Birth	Sex
Mailing Address	City	State	Zip Code
Service Address	City	State	Zip Code

**Responsible Party:**

Name (Last, First)	SSN#	Age	Date of Birth	Sex
Address (put same if same as above)	City	State	Zip Code	Marital Status S M D
Gross Annual Household Income	Home Phone	Cell Phone	Relation to Patient	

**Pediatrician or Referring Doctor:**

Name (Last, First)	Phone	Fax
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**Primary Insurance Information:**

Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code
Phone Number (Back of Card)	Co-Insurance %	Co-Pay	Group Name (Employer)

**Secondary Insurance Information:**

Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code
Phone Number (Back of Card)	Co-Insurance %	Co-Pay	Group Name (Employer)

**Patient Release**

I verify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payments of medical claims. I also authorize payment of the medical benefits to the provider. I acknowledge a fee at the provider's current rate may be charged on all "past due" balances.

Signature of insured or authorized person	Date
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**Internal Use Only**

Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis
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