**PATIENT REGISTRATION FORM**

**NAME: _____ D.O.B. _____/_____/_____**

**MALE / FEMALE MARRIED / SINGLE SS#: _____-_____-_____**

**EMAIL: _____**

**ADDRESS _____**

**CITY/ST/ZIP _____**

**DAYTIME PHONE: _____-_____-_____ ALT. PHONE: _____-_____-_____**

**EMPLOYER _____ WK PHONE: _____-_____-_____**

**REFERRING PHYSICIAN: _____**

**PRIMARY CARE PHYSICIAN: _____**

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**SPOUSE/PARENT/OTHER CONTACT: _____**

**PHONE:_____-_____-_____ RELATIONSHIP: _____**

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**PRIMARY INSURANCE: _____ (GIVE COPY OF CARD)**

**SECONDARY INSURANCE: _____ (GIVE COPY OF CARD)**

**INSURANCE HOLDER NAME: _____ D.O.B. _____/_____/_____**

**CARD HOLDER EMPLOYER: _____**

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**I acknowledge full responsibility for the payment of such services and agree to pay them in full, at or before completion, unless other payment arrangements have been made with the business office manager. I authorize my insurance carrier to issue the benefits of my plan directly to this office. I also authorize the release of any information necessary to process insurance. If the bill is not paid in a timely manner for any items or services I receive, the responsible party hereby agrees to pay all costs of collection, including reasonable legal fees.**

**Signed (patient or responsible party): _____**

**Date: _____**