

PATIENT REGISTRATION FORM

Patient Name _____ Today's Date: _____
(Dr., Mr., Mrs., Miss, Ms.) _____ Age: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Are you currently living in a skilled nursing facility? ____ Yes ____ No

Facility name: _____

Sex: M F Martial Status: Single Married Widowed Divorced

Social Security Number _____ - _____ - _____ Date of Birth: _____

Referred By: _____ Phone: _____

Family Physician: _____ Phone: _____

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Retired: _____

Spouse's Name: _____ Work Phone: _____

Insurance Information, please provide Insurance Cards:

Primary Insurance Name: _____

Secondary Insurance Name: _____

Routine Vision Plan: _____

If the Insurance Subscriber is anyone other than the patient please provide the following information

Subscriber name : _____ Relation to patient: _____

Address: _____

City _____ State _____ Zip _____

Home phone: _____ Work phone: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

If patient is a minor, please provide the following information for the responsible party:

Name: _____ Relationship to Patient: _____

Address _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

In case of Emergency,

Contact _____

Phone: _____

Relationship to Patient: _____

The following authorization permits us to provide information to your insurance company, Medicare, or other physicians and others who are legally entitled. Please Read Carefully.

Lifetime Authorization

I authorize reports of my evaluations, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers that I have or will identify to you. I also authorize release of all pertinent medical information to any hospital, out patient facility or clinic. **I understand that I am fully and legally responsible for payment of this account, which includes all outstanding balances not covered by Medicare and/or insurance companies.**

I authorize any holder of medical or other information about me to release to the social security administration and Health Care Financing Administration or its intermediates or carriers or to the billing agents of my insurance companies indicated above or to my employer if this is a worker's compensation claim, any information, including retirement dates, needed for this or related insurance or medicare claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Patient's Name (please print)

Patient's Signature

Date _____