

Patient Registration Form

PATIENT INFORMATION	
Patient Name:	_____
Address:	_____
City St Zip:	_____
2 nd Address:	_____
City St Zip:	_____
Birth Date:	_____ Age: _____
Gender:	M F
Ethnicity:	Hispanic Non-Hispanic
Language:	Eng Span Jap Fren Ital Portu
Marital Status:	S M D Sep Widow
Email Address:	_____
Method Contact:	Phone Mail E-mail
Social Security #	_____
Phone Number:	()
Cell Number:	()
Alt Number:	()
How did you hear about us:	

Primary Doctor:	
Your Race	Asian - Black - Caucasian - Hispanic Native American - Pacific Islander Black N-Hispanic - White N-Hispanic
Occupation:	_____
Employer name:	_____
Work Phone:	_____

EMERGENCY CONTACT	
Name:	_____
Phone number:	()
Relationship:	_____

RESPONSIBLE PARTY	
Name	_____
Relationship to pt:	_____
Address:	_____
Phone number:	()

PRIMARY INSURANCE	
Ins. Co. Name:	_____
Plan Name:	HMO PPO POS EPO AHCCCS (Circle one) Medicare Worker's Comp Indemnity
Effective date:	_____
Policy #:	_____
Copay:	\$ _____ % _____
Group #:	_____
Policy Holder:	
Name:	_____
Middle Initial:	_____
Date of Birth:	____ / ____ / ____
Gender:	(Circle one) M F
Relationship to pt:	(Circle one) Self Spouse Child
Employer :	_____
Insurance Phone:	()

SECONDARY INSURANCE	
Ins. Co. Name:	_____
Plan Name:	HMO PPO POS EPO AHCCCS (Circle one) Medicare Worker's Comp Indemnity
Effective date:	_____
Policy #:	_____
Copay:	\$ _____ % _____
Group #:	_____
Policy Holder:	
Name:	_____
Middle Initial:	_____
Date of Birth:	____ / ____ / ____
Gender:	(Circle one) M F
Relationship to pt:	(Circle one) Self Spouse Child
Employer :	_____
Insurance Phone:	()

AUTHORIZATION TO RELEASE INFORMATION: I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. These records can be transmitted by facsimile (FAX).

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician's clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

AUTHORIZATION FOR TREATMENT & DILATION: I hereby authorize medical treatment and dilation.

PATIENT SIGNATURE: _____ DATE: _____
(Parent Signature if Patient is a Minor)