REGISTRATION FORM

Section I: Patient Information

First Name:_____ Middle: _____ Last : _____

Social Security Number:_____ Date of Birth:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Gender:** ☐ Unknown ☐ Female ☐ Male

Race: ☐ Asian ☐ Black ☐ White ☐ Other ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Address:_____City:_____State:_____Zip_____

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

E-mail: _____

Contact in case of emergency_____ Phone_____ Relationship to Patient _____

Preferred pharmacy: _____Location:: _____ City: _____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

☐ Self-pay

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ ID#_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Group #_____ ID#_____

AGREEMENT

I do hereby consent to and authorize the performance of all treatments, surgery and medical services by the healthcare provider which he may deem advisable and agree to pay all charges incurred by reason thereof. I authorize the use of photographs in professional presentations to my insurance company, other patients and at medical lectures and seminars. I also hereby authorize release of information requested by my insurance company. I fully understand that this agreement and consent will continue until canceled by me in writing. I hereby authorize my insurance company to pay the healthcare provider directly for any medical or surgical benefits due to me for services rendered which I have not paid. A Photostat copy of this authorization is as acceptable as the original.

"I understand that it is policy in this office that payment for services be made at the time of the visit and that payment will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, unless prior arrangements have been made in writing."

The above information is for purpose of obtaining credit in this office and is warranted to be true. I authorize a representative to make credit investigation, including employment verification, in the event of non-payment of bills.

Signature: X _____ Date: _____