

**PATIENT REGISTRATION FORM**

**Please present your insurance cards and your photo ID to the receptionist so copies may be made.**

Title:  Mr.  Mrs.  Ms.  Miss Name: \_\_\_\_\_  Jr.  Sr.  
First Middle Last

Married  Single  Other \_\_\_\_\_

Address: \_\_\_\_\_  
Street # Street Name Apt #  
 \_\_\_\_\_  
City State Zip Code

Employer: \_\_\_\_\_  
Name Address Phone

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month / Day / Year

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex:  Male  Female

If Student:  Full Time  Part Time Name of School: \_\_\_\_\_

Where should statements of your account be sent if different from above?

\_\_\_\_\_  
Name Address Apt# City State Zip Code

Spouse: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_  
Month / Day / Year

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

\_\_\_\_\_  
 Signature of Parent or Legal Guardian Date

Insured Party (if different): \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_\_\_

Employed By: \_\_\_\_\_ Patient's relationship to insured:  Child  Other: \_\_\_\_\_

\_\_\_\_\_  
Address Phone

Do we have your permission to:

- Leave a message on your answering machine at home?
- Leave a message at your place of employment?
- Discuss your medical condition with any member of your household?
- If yes, whom: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
 Staff Signature

\_\_\_\_\_  
 Date

**MINOR PATIENT REGISTRATION FORM**

**Please present your insurance cards and your photo ID to the receptionist so copies may be made.**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last Month / Day / Year

Social Security #: \_\_\_\_\_ Sex:  Male  Female

Prefer to be called: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Address: \_\_\_\_\_  
Street # Street Name Apt #  
 \_\_\_\_\_  
City State Zip Code

If Student:  Full Time  Part Time Name of School: \_\_\_\_\_

Legal Guardian or Parent Name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Address Phone

Home Phone: \_\_\_\_\_ Parent/Legal Guardian Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

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It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

\_\_\_\_\_  
 Signature of Patient or Legal Guardian Date

Insured Party (if different): \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_\_\_

Employed By: \_\_\_\_\_ Patient's relationship to insured:  Child  Other: \_\_\_\_\_

\_\_\_\_\_  
Address Phone

Do we have your permission to:

- Leave a message on your answering machine at home?
- Leave a message at your place of employment?
- Discuss your medical condition with any member of your household?

If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
 Staff Signature Date