

Date _____ (PLEASE PRINT) Home Phone _____

- Patient Information -

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____

- Primary Insurance -

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birth date _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

- Primary Insurance -

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Birth date _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

- Assignment and Release -

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for
services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doc-
tor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

- Registration Form -