

REGISTRATION
(PLEASE PRINT)

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Date		Home Phone		Account #		Form #	
Patient Last Name				First Name		Initial	
Responsible Party (if a minor)							
Street Address							
City				State		Zip	
Sex	M <input type="checkbox"/>	F <input type="checkbox"/>	Age	Birthdate	Single	Married	Widowed
Separated		Divorced		Patient Employed By			
Business Address							
Occupation				Business Phone			
Spouse (or responsible party) Name					Birthdate		
Business Name and Address							
Occupation				Business Phone			
Who is responsible for this account?				Relationship to Patient			
Patient's Social Security number				Spouse's Social Security #			
Did you have Medical Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes >>> If yes,							
Name of Primary Insurer							
Group number		Subscriber number			Contact number		
Name of Secondary Insurer (if any)							
Group Number		Subscriber number			Contact number		
Medicare		Medicaid		Claim ID #			
E-Mail Address				Cell Phone			
In case of emergency who should be notified?						Phone	
How did you learn of our practice?							

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
 and assign directly to Dr. _____
 all medical 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 doctor
 to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____
 for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing
 Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my
 signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance"
 is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes
 releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge
 determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered
 services. Coinsurance and the deductible are based upon the charge demination of the Medicare Carrier.

Beneficiary Signature

Date