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REGISTRATION FORM

(Please verify the information we have. Make any changes or additions needed. Please print.)

Today's Date: | PCP:

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One)
					Single / Mar / Part/ Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex
❑ Yes ❑ No					

Street Address	City	State	ZIP Code	Social Security	Home Phone No.

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No.

E-mail address: ❑ Check here if you would like to communicate with office via E-mail

Person Responsible for Bill	Birth Date	Address (if different)	
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No.

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Empire Plan	❑ Empire BC/BS	❑ United Healthcare	❑ CIGNA
❑ Oxford	❑ Vytra	❑ GHI	❑ Aetna	❑ Other	

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims.

x |

PATIENT/GUARDIAN SIGNATURE | DATE