Patient Registration Form

Patient Information		Guarantor Information	
Patient Name		Guarantor Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Date of Birth		Date of Birth	
Sex		Sex	
Social Security #		Social Security #	
Email Address		Email Address	
Home Number		Home Number	
Mobile Number		Mobile Number	
Work Number		Work Number	

Emergecy Contact Related Person			
Name	Relationship	Home Phone	Mobile Phone

Primary Insurance		**Primary Subscriber Information**	
Payer Name		Name	
Health Plan Name		Relationship	
Contact Number		Address	
Group Number		City, State, Zip	
Member Number		Date of Birth	
Name on Card		Home Number	
Start Date		Mobile Number	
		Employer	

Secondary Insurance		**Secondary Subscriber Information**	
Payer Name		Name	
Health Plan Name		Relationship	
Contact Number		Address	
Group Number		City, State, Zip	
Member Number		Date of Birth	
Name on Card		Home Number	
Start Date		Mobile Number	
		Employer	

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to this provider for all covered medical services and supplies provided to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Authorization to Release Information

I authorize the release of any medical or any other information to the Center of Medicare and Medicaid (CMS), my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by this provider. A copy of this authorization will be sent to CMS, my insurance carrier(s), or other medical entity, if requested. This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Legal Guardian	Date
Print Name of Patient or Legal Guardian	