



PATIENT & PARTNER REGISTRATION FORM

DATE: _____

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(FEMALE)

NAME: _____
Last First Middle Initial Maiden/Other Name

NAME YOU WOULD LIKE TO BE ADDRESSED BY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # _____ OK TO LEAVE MESSAGE? Y / N

CELL PHONE # _____ OK TO LEAVE MESSAGE? Y / N

WORK PHONE # _____ OK TO LEAVE MESSAGE? Y / N

BIRTH DATE: _____ Age: _____ SS# _____ Driver Lic. #/State: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

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MARITAL STATUS: _____ PARTNER'S NAME: _____
Last First MI

ADDRESS (if different from patient's): _____

CELL PHONE # _____ OK TO LEAVE MESSAGE? Y / N

WORK PHONE # _____ OK TO LEAVE MESSAGE? Y / N

BIRTH DATE: _____ Age: _____ SS# _____ Driver Lic. #/State: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

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EMERGENCY CONTACT: _____ RELATION: _____

DAYTIME PHONE # _____ OK TO LEAVE MESSAGE? Y / N

OB/GYN: _____ PHONE # _____

WOULD YOU LIKE A LETTER SENT TO YOUR REFERRING DOCTOR? YES NO

REASON FOR VISIT? _____

PLEASE COMPLETE AND SIGN THE BACK OF THIS PAGE

Are you covered by Medical Insurance? If yes, please complete the following:

	PRIMARY INSURANCE *	SECONDARY INSURANCE
Subscriber Name:		
Relationship:		
Insurance Co. Name:		
Insurance Address:		
Insurance Phone:		
Group/Account Number:		
Subscriber/Identification Number:		
Employer:		

*If you have dual coverage, the insurance offered by the patient's employer is considered primary.

If your insurance is an HMO, you are responsible to obtain the initial authorization from your primary care physician.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician, and acknowledge that *I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE INSURANCE COMPANY.* I also authorize the physician to release any information required in the processing of this claim.

SIGNED: _____ DATE: _____
Patient

SIGNED: _____ DATE: _____
Partner

**PLEASE PROVIDE A COPY OF BOTH SIDES
OF YOUR INSURANCE CARD(s)**