

Today's Date _____

Patient Information/ Registration			
Patient Name:		Date of Birth:	Place of Birth:
Street Address: Apt.#		Comments:	
City, State, Zip:		Home Phone:	Work Phone
Other Addresses/Residences:		Mobile Phone:	Social Security #
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed/Divorced	Height	Weight	May we leave messages on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No ***(note: the representative from our office will never leave any personal health information)
Comments:			
Emergency Contact:	Relationship:	Home Phone:	Mobile Phone:
Employer:	Address:	Telephone	Extension:
Have you been seen by our practice before: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last Visit			

Insurance Information

Primary Insurance		
Company Name:	Policy ID#	Group#

Secondary Insurance		
Company Name:	Policy ID#	Group #

■ If Policy Holder is other than the Patient, please complete the following:

Policy Holder Name:	Date of Birth	SS#

Referring Physician Information		
Referring Physician		Is this the primary care giver? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:		If not, name of PCP:
City, State, Zip:		Telephone:

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I authorize payment of medical benefits to the physician, designated providers and corporations. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I understand I am also responsible for any legal, administrative, or collection agency fees that are incurred in collecting, my outstanding debts.

By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me:
Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; Notice of Privacy Practice; Notice of Medication Policies.

Signature of Patient or Responsible Party	Printed Name	Date
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