

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

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**ADULT REGISTRATION FORM**

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Street \_\_\_\_\_ apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell or alternate phone \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SELF: Name/Social Security # \_\_\_\_\_ date of birth \_\_\_\_\_ Spouse: Name/Social Security # \_\_\_\_\_ date of birth \_\_\_\_\_

Employer \_\_\_\_\_ work phone \_\_\_\_\_ Employer \_\_\_\_\_ work phone \_\_\_\_\_

**PRIMARY** Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Grp# \_\_\_\_\_

Address \_\_\_\_\_ SS # / ID # \_\_\_\_\_

Subscriber's birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (required for insurance billing)

**SECONDARY** Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Grp# \_\_\_\_\_

Address \_\_\_\_\_ SS # / ID # \_\_\_\_\_

Subscriber's birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (required for insurance billing)

EMERGENCY CONTACT: \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ phone \_\_\_\_\_ Referring Doctor \_\_\_\_\_ phone \_\_\_\_\_

address \_\_\_\_\_ address \_\_\_\_\_

Other family members seen in our office \_\_\_\_\_

**How did you learn of our office?** Circle one: Physician Friend Relative Website Advertisement Other \_\_\_\_\_

I hereby authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting an unpaid balances. **There is a \$25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

\_\_\_\_\_  
Signature of responsible party \_\_\_\_\_ date \_\_\_\_\_

**CO-PAYMENT IS DUE AT THE TIME OF SERVICE.**

A billing fee will be added to any copay not received in full at your appointment