

## REGISTRATION INFORMATION

### PERSONAL & WORK INFORMATION

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthdate: / / M F Social Security # - - Single Married

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_ Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

### FINANCIAL & INSURANCE INFORMATION

I will pay my balance in full at time of service.

Do you have Medical Insurance that covers Alternative Care Yes No

### REQUIRED INFORMATION

#### Primary Insurance

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

City: \_\_\_\_\_ St. \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Group or Plan or Program: \_\_\_\_\_

#### Secondary Insurance

Insured Name: self  \_\_\_\_\_ Insured Address: \_\_\_\_\_

Insured City: \_\_\_\_\_ St. \_\_\_\_\_ Zip: \_\_\_\_\_ Insured Phone # \_\_\_\_\_ Emergency # \_\_\_\_\_

Insured Social Security # \_\_\_\_\_ Insured Birthdate: / / \_\_\_\_\_

Insured Relationship to Patient: Spouse Child Partner  \_\_\_\_\_

How did you learn about our practice? friend ad yellow pages drive-by health professional other: \_\_\_\_\_

### RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

I here by authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician or supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense. **I will be responsible to the Provider for payment of the entire bill.**

\_\_\_\_\_  
Patient Signature or Guardian if patient is under 18 years of age

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