PATIENT REGISTRATION FORM

Patient Information:

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Social Security #: _____ Birthdate: _____

Gender: M◯F◯ Marital Status: S◯M◯D◯SEP◯W◯

Emergency Contact: _____

Emergency Contact Phone: _____

Is this a result of a motor vehicle accident or workers comp? Y◯N◯

Signature: _____ Date: _____

Guarantor Information:

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____

Social Security #: _____ Date of Birth: _____

Insurance Information:

INSURANCE CARRIER:	INSURED ID:	GROUP #:

ASSIGNMENT OF MEDICAL BENEFITS

I request that benefits be paid by my insurer or health plan (including Medicare) directly to the provider. If applicable, I understand that I will be responsible for any outstanding or unpaid balance on my bill.

CONSENT FOR TREATMENT/MEDICAL RECORD RELEASE

I authorize the Provider to furnish the necessary medical treatment or procedure, including diagnostic imaging procedures as ordered by the attending physician (s). I acknowledge that no guarantees have been made to me as a result of these diagnostic procedures. I recognize that the physicians who practice at the provider are not employees or agents of the center, but are independent physicians; the Provider may delegate to these independent physicians those services physicians normally provide; and any questions relating to my care my physician has given or ordered should be directed to him/her. I hereby authorize release of my medical records and/or x-rays for services rendered to me.

I understand provider will utilize information on this form to contact me in regards to business relating to my exam, treatment or payment. By providing this information, I am consenting to receiving calls both live and prerecorded, text messages, email and US postage.

_____ _____

Patient Signature Date