

Patient Registration Form

PATIENT NAME _____ RESPONSIBLE PARTY NAME _____

BILLING ADDRESS _____ CITY/STATE/ZIP _____

PERMANENT ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ CELLPHONE _____

SEX: M F BIRTHDATE _____ AGE _____

SOCIAL SECURITY # ____ - ____ - ____ RESPONSIBLE PARTY SS# ____ - ____ - ____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER _____

REFERRING DOCTOR: _____

IF INJURY RELATED TO AN ACCIDENT, WAS IT: AUTO ACCIDENT or JOB RELATED INJURY: DATE OF INJURY _____

MARITAL STATUS: _____

SPOUSE OR NEAREST RELATIVE NAME/ADDRESS/PHONE _____

EMPLOYER:NAME/ADDRESS/PHONE _____

INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

INSURANCE CO. NAME _____

INSURANCE CO. NAME _____

INS. CO. ADDRESS _____

INS. CO. ADDRESS _____

POLICY HOLDER NAME _____

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

RELATIONSHIP TO PATIENT _____

EMPLOYER _____

EMPLOYER _____

POLICY # _____ GROUP/CLAIM# _____

POLICY# _____ GROUP/CLAIM# _____

POLICY HOLDER SEX: M or F BIRTHDATE _____

POLICY HOLDER SEX: M or F BIRTHDATE _____

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COPAY\$ _____ DEDUCT\$ _____

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA") I HEARBY AUTHORIZE DR. GLENN HINCHMAN AND/OR NURSE PRACTITIONER EMILY SEIDEN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN AND/OR NURSE PRACTITIONER ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I PROMISE TO PAY COLLECTION COST AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION OF THIS ACCOUNT.

Initial _____ I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED THE "HIPPA" NOTICE OF PRIVACY PRACTICES AND GENERAL OFFICE POLICY INFORMATION

SIGNATURE AND RELATIONSHIP TO PATIENT

DATE