PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Sex: ○ Female ○ Male Birth date: _____ Social Security #: _____

E-mail: _____ □ I would like to receive email correspondence

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Birth date: _____ Social Security #: _____

E-mail: _____ □ I would like to receive email correspondence

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Birth date: _____ Employer or Subscriber ID: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Birth date: _____ Employer or Subscriber ID: _____

Employer: _____ Insurance Company: _____

HIPAA Consent:

I have been given the right to review and secure a copy of your *Notice of Privacy Practices.*
I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

Patient Name: (print)_____

Signature: _____

Relationship to patient: _____ **Date:** _____