REGISTRATION FORM

Today's Date: _____/_____/_____

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

Birthdate: _____/_____/_____ Social Security Number: _____-_____-_____ Gender: M / F

Marital Status (circle one): Single Married Widowed Divorced

Address: _____Unit/Apt.#: _____

City: _____ State: ____ Zip: _____ Email: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Occupation: _____ Work Phone: (____)_____

Work Address: _____ City: _____ State: ____ Zip: _____

Spouse's Name: _____

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

PRIVATE INSURANCE

Insurer: _____ Policy #: _____Group #:_____

Subscriber's Name, if different from above: _____

Subscriber's DOB: _____/_____/_____

Patient's relationship to subscriber: □ Spouse □ Child □ Other: _____

AUTHORIZATION

The information above is true to the best of my knowledge. In the event that I fail to pay my bill for services rendered, I hereby consent to the release of all information regarding my bill, as an effort to collect. I understand this information would only be released to the collection agency or an attorney, if it pertained to the collection of my debt, and that this collection agency and/or attorney will abide by confidentiality regulations.

Signature: _____ Date: _____/_____/_____