REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Physician:**					
Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐Miss ☐Ms.	Marital status (check one) ☐Single ☐ Mar ☐Div ☐Sep ☐ Wid	
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐M ☐F	
Street address:	Social Security no.:	Home Phone:_____ Cell:_____				
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.:				
Spouse Name:	Spouse DOB:					
RACE: ETHNICITY: ☐DECLINE ☐HISPANIC/LATINO ☐ NOT HISPANIC/LATINO						
PATIENT'S E-MAIL ADDRESS:						
PATIENTS PRIMARY INSURANCE:						
Subscriber's name:	Subscriber's ID #	Birth date:	Group no.:		Co-payment: (if known) $	
Patient's relationship to subscriber: ☐Self ☐ Spouse ☐ Child ☐ Other						
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #.:			
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:			

Patient OR Guardian OF Patient signature: *Date:*

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patients Signature: _____ Date: _____