REGISTRATION FORM

PLEASE READ CAREFULLY - INFORM THE FRONT DESK OF ANY CHANGES

The Front Desk Staff will Scan your Insurance Card and Driver's License into your Electronic Medical Record

NAME: ______________________________________

DOB: ___________________________________

SOCIAL SECURITY#: ________________________

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: _________________ **WORK PHONE:** ___________________ **CELL PHONE:** __________________

E-MAIL: ____ **Preferred Communication Method:** ◻ **Phone** ◻ **Email** ◻ **Text**

SEX: ◻ Female ◻ Male ◻ Unknown

ETHNICITY/RACE: _______________________________________

MARITAL STATUS: ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Separated

EMPLOYER: ____________________________________ **EMPLOYER PHONE:** ____________________

EMERGENCY CONTACT: ____________________________________ **PHONE:** ____________________

INSURANCE:

INSURANCE CARRIER: Primary: ______________________ **INSURED/DOB** _________________ **ID#** _________________________

Group# ________________________ **Secondary:** ____________________________

ID# ______________________________ Group# ____________________

GUARANTOR INFORMATION (FINANCIALLY RESPONSIBLE FOR MINOR):

Name: ____ Relation to patient: ____________________

Address:____ DOB: ___________________

Guar SSN#:____ Phone #: ______________________________

REFERRING PHYSICIAN: ___________________________________ Phone: ___________________________

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RELATED PROVIDERS:
Primary Care Physician(PCP): _____________________________ Phone: ____________________________

Cardiologist: ____ Phone: ____________________________

Other related provider: ___________________________________ Phone: ____________________________

PATIENT'S PREFERRED PHARMACY/PHARMACIES:

Primary Pharmacy: ____

Phone: ________________________ Fax: ________________________

Mail order Pharmacy: ____

Phone: __________________________________ Fax: __________________________________

Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/financial arrangements should be made with our business office prior to any scheduled SURGERIES.

____ Date: _______________
Patient signature