Patient Registration Form

Patient Information

First Name | Last Name | Date of Birth

Gender | Marital Status | Social Security

Mailing Address | City | State | Zip

Home Phone | Cell Phone | Email Address (We will never share your email address - we value your privacy)

How did you hear about the practice?

- ❏ Internet/Google
- ❏ Website
- ❏ Facebook   Referred by:_______________
- ❏ Billboard
- ❏ Phonebook   Other:_____________________

May we leave a message:

- -with your **spouse/significant other**? Yes No
- -on your **answering machine**? Yes No
- -with a **family member**? Yes No

Medical Insurance Information

Employer

Primary Insurance | Secondary Insurance

Primary Care Physician (PCP): | Preferred Pharmacy (Town)

Emergency Contact Information

Name | Phone # | Relationship to Patient

Address

I authorize release of my personal health information to the following:

Name | Relationship | Name | Relationship

We occasionally send information regarding your care to your primary care physician and or referring doctor.
We are required to release information to your insurance company.
I hereby authorize and assign my insurance benefits (VA patient exempt) to be paid directly to the physician and or facility I understand that I am financially responsible (VA patient exempt) for all non-covered services. I also authorize the release any information required in processing this claim.

Signature | Date