Registration and Demographic Verification Form

Patient Name:____ Date of Birth:____________________
Address:____ Age:_____________ Sex: M__ F__
City:_______________________________State:_________________Zip code:_________________________
Home #_______________________ Work_________________________ Cell #_________________________
Social Security #_________________________________ Marital Status: M__ S__ D__ W__
Are you a new or former patient to this office: New / Former
Name and location (or phone#) of Primary Doctor____
Name and location (or phone#) of Referring Doctor____

Guarantor Information (Responsible party; parent; guardian)

Name:____ Date of Birth ____________________
Address:____________________________________ Age:____________ Sex: M__ F__
City:___________________________State:_________________ Zip Code: ___________________
Home Number_____________________________ Work Number __________________________
Relationship to patient ____

Insurance information

Primary insurance information:
Insurance Co______________________________
Policy holder's Name:______________________
Policy holder's SS# _________________________
Policy holder's Date. of Birth:_______________
Relationship to patient:_____________________

Secondary insurance information: (if applicable)
Insurance Co:______________________________
Policy holder's Name:______________________
Policy holder's SS#: _______________________
Policy holder's Date of Birth:________________
Relationship to patient:_____________________

Patient's Employer Information

Company Name_______________________________ Company Address_______________________________
Occupation:___________________________________ Phone Number _________________________________

Your Spouse's Employer Information

Company Name____ Occupation_______________________

Emergency Contact

Name____ Phone #___________________________________
Relationship to patient____

PLEASE READ THE FOLLOWING INFORMATION REGARDING PAYMENT AND MEDICAL RECORDS

I understand that my private healthcare information (PHI) will be used in the treatment, payment and healthcare operations (TPO) of this office only and will not be used otherwise without my authorization. I also acknowledge that, I have received a copy of the office policy and privacy policy as used in this office. I also understand that if the services rendered are not covered by my insurance plan, I will be responsible for payment and will be expected to make such payment as soon as that information is made available to me. In order to maximize insurance benefits, I consent to the release of medical records and other documentation to my insurance company as needed.

Signature of patient or responsible party: ____
Today's Date: ______________________