REGISTRATION FORM

☐ I acknowledge and agree that payment is expected at the time of service, including co-payments and co-insurance.

(PLEASE PRINT)

DATE: _____ FIRST NAME: _____ LAST NAME: _____

BIRTHDATE: _____ NICKNAME: _____

GENDER: ☐ M ☐ F

AGE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ ETHNICITY: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____ PHONE: _____

INSURANCE:

POLICY HOLDER'S FULL NAME: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

POLICY HOLDER'S DATE OF BIRTH: _____

ASSIGNMENT & RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____
NAME OF INSURANCE

AND ASSIGN DIRECTLY TO DR. _____ ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER THEY'RE PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL THE INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE OF INSURED/GUARDIAN _____ **DATE:** _____