

## Patient Registration Form

MRN# :	S.S.#:	Date:		
Patient's Last Name:	First Name:	Middle Initial:	Student? FT or PT	
Home Address:		Email Address:		
City:	State:	Zip:	Home ph#(s):	
Date of Birth:	Marital Status:	Race:	Sex:	Contact/Cell#:
Employer:	Employer Address:			
Spouse's Name:	Spouse's Employer:			

### Person Responsible for bill:

Name:		Relationship to Patient:		
S.S.#:	Date of Birth:	Sex:		
Home Address:				
City:	State:	Zip:	Home ph#(s):	
Employer:	Employer Address:			
City:	State:	Zip:	Contact/Cell#:	

### Emergency Contact Information

Name:		Relationship to Patient:		
Home Address:				
City:	State:	Zip:	Home ph#:	
Employer:	Employer Address:			
City:	State:	Zip:	Contact/Cell#:	

### Insurance Information

#### Primary Insurance Company:

Insurance Co. Address:				
Policy #:	Group #:	Effective Date:	Group Name:	
Subscriber Name:		Relationship to Patient:		
S.S.#:	Date of Birth:	Sex:		
Subscriber Address:				
Primary Care Provider:				

#### Secondary Insurance Company:

Insurance Co. Address:				
Policy #:	Group #:	Effective Date:	Group Name:	
Subscriber Name:		Relationship to Patient:		
S.S.#:	Date of Birth:	Sex:		
Subscriber Address:				
Primary Care Provider:				

#### NOTICE OF CREDIT BALANCE REFUND POLICY

As a part of our ongoing effort to minimize administrative costs associated with billing and collecting charges for the professional services of our physicians, credit balance refunds of less than \$5.00 are not processed for patients who have not received services in our healthcare network for greater than 12 consecutive months (unless specifically requested by the patient within such 12 month period).