PATIENT REGISTRATION

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PATIENT INFORMATION

Name – Last First Middle				Patient Status ☐ Single ☐ Married ☐ Other ☐ Employed ☐ Part-time student ☐ Full-time student
Patients Birth date:	Sex SocS ☐M ☐F	Social Security Number	Drivers License Number	Home Phone Number ( )
Mailing Address: Number & Street City State & Zip				Cell Phone Number ( )
Employer	Occupation			Work Number ( )
Primary Care Physician	Referring Physician			

RESPONSIBLE PARTY INFORMATION

Complete this section if someone other than the patient will be responsible for the bill.

Name – Last First Middle			Relationship to the Patient
Patients Birth date:	Sex SocS ☐M ☐F	Social Security Number	Drivers License Number
Mailing Address: Number & Street City State & Zip			Home Phone Number ( )
Employer	Occupation		Business Phone Number ( )

SIGNIFICANT OTHER/ SPOUSE INFORMATION

Name- Last First Middle		Social Security Number	Home Phone Number ( )
Employer	Occupation		Business Phone Number ( )

EMERGENCY PHONE NUMBER

Name- (Someone NOT living with you)	Relationship	Phone Number ( )

INSURANCE INFORMATION

Full Name of Insurance Company			Billing Address for Claims	
Insurance carried in Whose Name (Insured)		Patient's Relationship to Insured	Insured's ID Number	Policy Number
Insured's Birth date	Sex ☐ M ☐ F	Group Number	Employer or School Name	Insurance Plan Name or Program Name
Other Insurances--Full Name of Insurance Company			Billing Address for Claims	
Insurance carried in Whose Name (Insured)		Patient's Relationship to Insured	Insured's ID Number	Policy Number
Insured's Birth date	Sex ☐ M ☐ F	Group Number	Employer or School Name	Insurance Plan Name or Program Name

ASSIGNMENT FOR INSURANCE BENEFITS

I hereby authorize the release of any medical information necessary to process any insurance claims	I hereby authorize payment directly to Dr. Mishra/ for medical services provided. I understand that I am responsible for all charges regardless of insurance coverage.
_____/_____ _____ Patient, Parent or Guardian Signature / Relationship Date	_____/_____ _____ Patient, Parent or Guardian Signature / Relationship Date