Date _____ **(PLEASE PRINT)** **SS#**____ ____ ____
Use black Ink

Patient Information:

Age_____

Name _____
Last Name **First Name** **Middle Initial**

Address _____ City _____

State _____ Zip_____ DOB____ ____ ____

Home # (____)_____ Work#(____)_____ Cell#(____)_____

Email address _____

Sex (M) (F) Married____ Sep____ Widowed____ Div____ Single____ Minor____

Emergency Contact_____ Phone #_____

Patient Employer/School_____

Employer Address_____ Ph#_____

Whom may we thank for referring you?_____
If physician referred- phone # (____)_____
If diabetic, Physician treating you _____ **Last seen**_____

Primary Insurance Information:

Insured's Name_____
Last **First** **MI**
Relationship to Patient_____ SS#_____

DOB_____ Address (if different than patient)_____

_____

Employer of Insured_____

Business Address_____

Business phone (____)_____ Occupation_____

Insurance Co_____

ID#_____ Group_____ **over**

Additional Insurance:

Is patient covered by additional insurance? Yes_____ No_____

Insd's Name _____ Relation to Patient_____ DOB_____

Address (if different from patient)_____

City_____ State_____ Zip_____ Ph#(___)_____

Subscriber Employed by_____

Business Phone(____)_____ SS#_____

Insurance Company_____

ID#_____ Group Name_____ Group#_____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative **Date**

Registration Form