

PATIENT REGISTRATION FORM

Please Print and complete all sections below

Is your condition a result of a work injury? Yes _____ No _____ Auto Accident? Yes _____ No _____

PERSONAL INFORMATION Marital Status: Married _____ Single _____

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age _____ Occupation _____

Employer _____ Phone _____

Spouse's Name _____ Work Phone _____ Social Security # _____

How do you wish to be addressed? _____

Would you like to receive our Free Women's Health Newsletter?

If yes, please include your email address: _____

PATIENT / RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Phone _____

INSURANCE INFORMATION Complete only if your insurance covers our services (we do not bill secondary Ins.)

PRIMARY insurance company name _____ Social Security # of insured _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Name of Insured _____ Date of Birth _____

Insurance ID number _____ Group Number _____ Claim # _____

How did you hear about our office? _____

Referred by (if applicable) _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I authorize payment of benefits be made directly to Premier Acupuncture & Complementary Medicine. I understand I am responsible for charges not covered by my insurance. I authorize the release of any medical records necessary to process any and all claims filed now or in the future.

Signature _____ Date _____