REGISTRATION RECORD

PLEASE PRINT THE FOLLOWING INFORMATION. IF YOU NEED ASSISTANCE IN FILLING OUT THIS FORM, PLEASE ASK FOR HELP.

TODAY'S DATE _____

PATIENT'S NAME _____ M F S M D W
First Middle Last Sex Marital Status

PATIENT'S ADDRESS _____
Number and Street City, State Zip

PATIENT'S PHONE ( ) SOC. SECURITY # - - DATE OF BIRTH:

MESSAGE PHONE ( ) E-MAIL

EMPLOYER OF PATIENT

EMPLOYER'S ADDRESS _____
Number and Street City, State Zip

EMPLOYER'S PHONE ( ) **REFERRING PHYSICIAN**

RESPONSIBLE PARTY _____
Name Address City, State Zip

RESPONSIBLE PARTY'S PHONE ( ) S.S.# - - EMPLOYER

RESPONSIBLE PARTY'S EMPLOYER PHONE ( ) ADDRESS:

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE CO. _____
Number and Street City, State, Zip

NAME OF INSURED PERSON

INSURED PERSON'S DATE OF BIRTH

SOCIAL SECURITY # OF THE INSURED PERSON - -

GROUP & POLICY NUMBER

NAME OF 2ND INSURANCE COMPANY

ADDRESS OF 2ND INSURANCE CO. _____
Number and Street City, State, Zip

NAME OF INSURED PERSON 2ND INSURANCE

INSURED PERSON'S DATE OF BIRTH 2ND INSURANCE

SOCIAL SECURITY # OF THE INSURED PERSON 2ND INSURANCE - -

GROUP & POLICY NUMBER 2ND INSURANCE

PLEASE PRESENT ANY COMPLETED INSURANCE FORMS OR CARDS AVAILABLE

PERSON TO CONTACT IN CASE OF EMERGENCY

TELEPHONE NUMBER ( ) RELATIONSHIP

ADDRESS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST THAT PAYMENT OF ALL BENEFITS BE MADE TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED BENEFITS AND ALL DEDUCTIBLES NOT COVERED BY THIS AUTHORIZATION. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEY'S FEES AND COLLECTION EXPENSES.

SIGNED (INSURED OR AUTHORIZED PERSON) _____ DATE _____

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES, INCLUDING PHONE NUMBER CHANGES. PLEASE RETURN THIS FORM TO THE RECEPTIONIST. THANK YOU FOR YOUR COOPERATION.

Revised January 2003