PATIENT REGISTRATION FORM

Please fill out form completely. See Notice of Privacy Practices

STOP : Is today's visit work related? If yes: Do not complete this form. Please see front desk staff for instructions.

Patients Full Name:_____
Date of Birth: _____ Sex: ☐ M ☐ F
Street Address / Apt # :_____
_____
Home Phone: _____Leave Message ☐ Yes ☐ No
Cell Phone: _____Leave Message ☐ Yes ☐ No
Work Phone: _____
Best form of contact? ½ Home ½ Cell ½ Other
Primary Care Physician: _____
Primary Care Phone or City & State:_____

Social Security #:_____
REASON FOR VISIT:_____
_____
Was this the result of a motor vehicle accident? ½ Yes ½ No
How did you hear about us?_____
Home Email Address:_____
Confidential Email Address:_____
Emergency Contact :_____
Emergency Contact Phone:_____
Relationship to Patient: _____

Based on government regulations we are required to ask the following: ½ I prefer not to answer

Preferred Language: _____
Ethnicity: ½ Hispanic or Latino
½ Non Hispanic or Latino

Race: ½ American Indian or Alaska Native ½ Asian
½ Black or African American ½ Caucasian
½ Native Hawaiian or Other Pacific Islander

GURANTOR INFORMATION ½ Check if same as patient information and sign at X below. If not, please complete entire section and sign.

Name: _____ Sex: ☐ M ☐ F
Date of Birth:_____ SSN#:_____
Street Address/Apt #:_____
City, State, Zip:_____
Home Phone:_____
Local or Cell Phone:_____Email:_____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other
Guarantor Employer:_____

Employer Phone:_____ Exit #:_____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office in the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs if any.

X_____DATE:_____
Patient/Guardian Signature

INSURANCE INFORMATION

Primary Insurance
Insurance Plan Name: _____
Policy ID: _____ Group Number: _____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Relationship to Insured : ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber Name:_____
Subscriber Date of Birth:_____

Secondary Insurance (if applicable)
Insurance Plan Name: _____
Policy ID: _____ Group Number: _____

Relationship to Insured : ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber Name:_____
Subscriber Date of Birth:_____

CONSENT FOR TREATMENT I, the undersigned, consent to the care and treatment by the attending physician, his/her associates and assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

SIGNED:_____ DATE: _____
Patient/Guardian Signature (If patient is a minor)

I have reviewed the GoNow Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

SIGNED:_____ DATE: _____