

REGISTRATION FORM

(Please Print)

Today's date:		Referred by:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one)	
						Single / Mar / Div / Sep / Wid	
Cell Phone Number:	Drivers License Number/State:	Social Security Number:		Birth date:	Age:	Sex:	
()				/ /		<input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Apt. Number		Home phone no.:		
					()		
P.O. box:	City:		State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.:			
				()			
Email Address:							
INSURANCE INFORMATION							
(Please give your insurance card and drivers license to the receptionist.)							
Name of Primary Insurance:	Prior Auth Req?	Authorization Number:			Insurance Phone No.:		
	<input type="checkbox"/> Yes <input type="checkbox"/> No				()		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:		
		/ /			\$		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:		Policy no.:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.:		Work phone no.:	
				()		()	
ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION							
I assign and request payment of medical benefits be made to Andrew D. Smith, M.D., Inc. for medical services rendered. I authorize the release of medical information necessary to process my claim. I have read the Financial Policies and understand that I am financially responsible for any non-covered services.							
Patient/Guardian signature				Date			