PATIENT REGISTRATION

Patient Information

Today's Date_____ **Birthdate**_____**Age**_____

Name_____Social Security#_____
Last Name First Name M.Initial

How do you wish to be addressed? _____

Address_____Home Phone_____

City_____State_____Zip Code_____

Sex ☐M ☐F ☐Single ☐Married ☐Widowed ☐Divorced

Business Phone_____Alternate Phone_____

Patient Employed by_____Occupation_____

Business Address_____City_____State___Zip_____

☐Full Time ☐Part Time ☐Retired ☐Not Employed ☐Student

Spouse's Name_____D.O.B._____

Social Security#_____Employer_____

In Case of Emergency_____Phone_____

Primary Insurance

Subscriber Name_____Relation_____D.O.B._____

Insurance Company_____Plan Type_____

ID#_____Group#_____

Additional Insurance

Subscriber Name_____Relation_____D.O.B._____

Insurance Company_____Plan Type_____

ID#_____Group#_____

Assignment and Release

I, the undersigned, certify that I or my dependent) have insurance coverage with _____ (Name of Insurance Company) and assign Dr. Thomas K. Alexander or Dr. Trung N. Dao 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 hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date