NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Contact Information

First Name ___________________________

Last Name ___________________________

Daytime Phone ___________________________

Mobile Phone ___________________________

Email ___________________________

Street Address ___________________________

Suite/Apt. ___________________________

City ___________________________

State ___________________________

Zip Code ___________________________

Guardian Information *(If patient is under 18 years of age)*

First Name ___________________________

Last Name ___________________________

Daytime Phone ___________________________

Mobile Phone ___________________________

Email ___________________________

Street Address ___________________________

Suite/Apt. ___________________________

City ___________________________

State ___________________________

Zip Code ___________________________

Patient Information

Gender ___________________________

Date of Birth ___________________________

Social Security No. ______________________

Medical Insurance Information

Provider Name ___________________________

Provider Phone ___________________________

Policy/I.D. No. ___________________________

Group No. ___________________________

Vision Insurance Information

Provider Name ___________________________

Provider Phone ___________________________

Policy/I.D. No. ___________________________

Group No. ___________________________

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgement of Notice of Privacy Practices (NPP)

Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.

No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.

The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms ______________________________ Date _______________