

'WELCOME TO OUR OFFICE' Registration Form

- Please PRINT your answers clearly to the following instructions.
- Please give your INSURANCE CARD(S), DRIVER'S LICENSE, & REFERRAL (if applicable) to the receptionist. A COMPLETE ADDRESS IS NECESSARY FOR OUR RECORDS.
- We would like to make your experience in our office pleasant. We prefer to complete all the business aspects of your visit when you first enter the office. We require the following during your visits to our office:
 1. Copayments are collected upon entering the office. There is a \$10 fee to bill for forgotten copays.
 2. Please notify us if you have any changes in your insurance companies. We need to photocopy your cards.
 3. We require a copy of your insurance cards and referral to process your claim. If you do not have one or more of these items we will be glad to honor your visit. However, full payment is expected at the time of service.
 4. FYI: If you need to cancel your appointment we require a 24 hour notification so we can reschedule that time period. Appointments that are missed and not cancelled prior to 24 hours before the scheduled time are subject to a \$25 charge.
- Should you have any questions, please do not hesitate to ask for assistance. Thank you.

PATIENT INFORMATION: (Please print)

First Name: _____ Middle Initial: _____ Last Name: _____

Address 1: _____ City: _____ State: _____ Zip Code: _____

Work Phone () _____ Home Phone () _____ SS# _____
(FULL HOME ADDRESS REQUIRED: NO P.O. BOX)

Address 2: _____ City: _____ State: _____ Zip Code: _____

Please circle the appropriate answers to the following:

SEX Male Female Marital Status Single Married Legally Separated Divorced Widowed

*** Date of Birth: (including year) _____

EMPLOYMENT OF THE INSURED Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Status: (please circle) Full Time Part Time Retired Unemployed Disabled

ADDITIONAL INFO 1. Primary Care Physician: _____
City _____ State _____ Phone# () _____

2. Pharmacy Name: _____
City _____ State _____ Phone# () _____

*DO YOU HAVE A PRESCRIPTION PLAN FOR YOUR MEDICATIONS? YES NO

We appreciate every referral. It tells us that we are providing the care that you deserve and expect. Whom may we thank for referring you to our office? NAME: _____
ADDRESS: _____
Did you hear of us from an advertisement? If so, which one? _____

PLEASE TURN THE PAGE & COMPLETE THE BACK OF THIS REGISTRATION FORM THANK YOU!

