Registration Form

debradietworks
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NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____
HOME CELL WORK

BIRTH DATE: / / **SS#:** **SEX:** M ___ F___

MARITAL STATUS: **MARRIED**___ **SINGLE** ___ **DIVORCED** ____ **WIDOWED** ___

EMPLOYERS NAME/ADDRESS: _____

_____

SPOUSES NAME/PHONE: _____

SPOUSES EMPLOYER: _____

REFERRING DOCTOR: _____

DO YOU HAVE MEDICARE: **YES** __ **NO**__ **PRIMARY**__ **SECONDARY** __ **MEDICARE #:**

PRIMARY INSURANCE COMPANY: _____

ID#: **GROUP#:**

PATIENT RELATIONSHIP TO INSURED: **SELF** ____ **SPOUSE** ___ **CHILD** ___ **OTHER** ___

INSURED'S NAME (if not the same)**:** _____

SECONDARY INSURANCE COMPANY: _____

ID#: **GROUP#:**

PATIENT RELATIONSHIP TO INSURED: **SELF** ____ **SPOUSE** ___ **CHILD** ___ **OTHER** ___

INSURED'S NAME (if not the same)**:** _____

ADDRESS: _____

I authorize any holder of medical or any other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits either to myself or to the party who accepts assignment.

If you belong to an HMO to which the practice participates, the patients' responsibility is restricted to the applicable co-pay.

SIGNATURE: _____ **DATE:** _____

EMERGENCY CONTACT: _____
NAME PHONE RELATIONSHIP