REGISTRATION FORM

Full Name: _____
Date of Birth: ___ / ___ / _____
Gender: □ Male □ Female □ Other
Social Security Number: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone Number: _____
Email: _____

Emergency Contact
Name: _____
Relationship: _____
Phone Number: _____
Insurance Information
Primary Insurance Company: _____
Policy/ID Number: _____
Group Number: _____
Policy Holder's Name: _____
Secondary Insurance (if any): _____

Medical Information
Primary Care Physician: _____
Referring Physician: _____
Current Medications: _____
Allergies: _____
Past Medical History: _____
Surgical History: _____
Consent & Authorization
□ I consent to treatment and authorize the release of medical information necessary for insurance processing.
□ I authorize payment of medical benefits directly to the provider.

INSURANCE NAME: _____

Signature: _____ Date: ___ / ___ / _____

I