

PATIENT REGISTRATION INFORMATION

Date of Birth

Last Name _____ First Name _____ Middle Initial _____ Sex _____ Month _____ / Day _____ / Year (xxxx) _____

Mailing Address _____ City _____ State _____ Zip Code _____

Primary Telephone Number _____ Other Telephone _____ Email Address _____

Primary Language: _____ Do You Need An Interpreter? Yes No Ethnicity: _____

Hearing Impaired? Yes No Vision Impaired? Yes No

Primary Care Physician _____ Referring Physician _____

EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____ Relationship to Patient _____ Telephone Number _____ Legal Guardian? Yes No

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Last Name _____ First Name _____ Relationship to Patient _____ Telephone Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

MEDICAL INSURANCE POLICY HOLDER

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Primary Insurance Company: _____	Secondary Insurance: _____
Policy Holder Last Name: _____	Policy Holder Last Name: _____
Policy Holder First Name: _____	Policy Holder First Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber ID: _____	Subscriber ID: _____
Group ID: _____	Group ID: _____

ASSIGNMENT OF BENEFITS / CONSENT FOR TREATMENT

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by the attending providers.

_____ *Signature of Patient or Patient's Legal Representative* _____ *Month / Day / Year*

_____ *Printed Name of Patient or Legal Representative* _____ *Relationship to Patient*