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**Patient Registration**  
Please fill out completely

Patient Name:	MI:	Last:
Street Address:		
City:	State:	Zip:
SSN:	Gender ( )M ( )F	
HomePH: ( )	WorkPH: ( )	
Date of Birth: / /	Age:	
Employer:		
Employment: ( )Employed ( )FT Student ( )P/T Student ( )Retired ( )Other		
Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Other		
Referred By:		
In case of emergency contact:		
Relationship:	Phone:	

**Primary Insurance**

Insurance Company Name:	Phone:( )
Claims Address:	
City, State. Zip:	
Subscriber's Name:	Date of Birth: / /
Relationship to you: ( )Self ( )Spouse ( )Parent ( )Other	
I.D./Claim# as shown on card:	Group/Policy #:
Employer:	

**Secondary Insurance or Auto/L&I**

Is this visit injury related? ( )Y ( )N		Work related? ( )Y ( )N	
Auto Accident? ( )Y ( )N		State:	
Insurance Company Name:	Phone:( )		
Claims Address:			
City, State. Zip:			
Subscriber's Name:			
Date of Birth: / /			
Relationship to you: ( )Self ( )Spouse			
I.D./Claim# as shown on card:		( )Parent ( )Other	
Employer if applicable:		Group/Policy #:	

*I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment be made directly to the physician.*

Signature: \_\_\_\_\_ Date \_\_\_\_\_