Date: ___________________________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST- -FIRST- -MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	PRIMARY PHONE #	ALT PHONE #
PATIENT BIRTH DATE	PATIENT SSN	SEX □MALE □FEMALE	MARITAL STATUS □SINGLE □MARRIED□ □ OTHER _____________
RACE	LANGUAGE	REFERRING DOCTOR	
PRIMARY DOCTOR/FAMILY DOCTOR	EMERGENCY CONTACT/RELATIONSHIP	EMERGENCY PHONE NUMBER:	
LOCAL PHARMACY	EMAIL ADDRESS		

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	OWNER OF INSURANCE POLICY	RELATIONSHIP	DOB:
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
IS YOUR CONDITION COVERED UNDER A WORKMANS COMP CLAIM/AUTO INSURANCE CLAIM? (YES OR NO)	POLICY NUMBER AND DATE OF INJURY		
SECONDARY INSURANCE NAME	OWNER OF INSURANCE POLICY	RELATIONSHIP	DOB:
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

Delinquent accounts will be charged interest at 1 1/2 % per month.
The undersigned specifically agree to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

SIGNATURE (PATIENT OR, IF MINOR SIGNATURE OF PARENT OR GUARDIAN)	DATE

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (OPTIONAL):