Patient Registration Form

Name: _____ **Social Security #** _____

Home Address: _____ **Date of Birth**_____ **Age**_____

City: _____ **State:** _____ **Zip:** _____

Telephone: (H) _____ **(W)** _____ **(Cell)** _____

Marital Status: **S M W D** **Spouse Name:**_____
Patient Employer:
Employer Name: _____ Occupation: _____

Insurance Information
Primary Policy
Name of the Insured: _____ SS#:_____

Insurance Company Name:_____ ID#:_____

Copay Due per Visit: _____ Insured Date of Birth: _____

Secondary Policy
Name of the Insured: _____ SS#:_____
Insurance Company Name: _____ ID#:_____
Copay Due per Visit: _____ Insured Date of Birth: _____

Responsible Party Information
Name: _____ Relationship: _____

Address: _____ Telephone: _____

City:_____ State:_____ Zip:_____

Emergency Contact
In case of emergency contact: Name: _____ Phone #_____

Address:_____ Relationship:_____

If under 18, legal guardian Name: _____ Relationship: _____

INSURANCE AUTHORIZATION: ASSIGNMENT OF RELEASE OF INFORMATION:
I, the undersigned, authorize payment of medical benefits to Susan Buckler-Miller, MSW, LSW for services or supplies furnished to me by the health care provider. I understand that I am financially responsible for any amount not paid by my insurance company. Finance charges and collection fees may be added to the account for overdue balances. I also authorize the release of medical information for the purpose of administering insurance claims of Benefits.
MEDICARE LIFETIME SIGNATURE ON FILE: I request payment of authorized Medicare/Supplemental benefits be made on my behalf, for services or supplies furnished by the health care provider.

_____ _____
Signature Date