

Patient Registration Form

NAME _____
First Middle Last

ADDRESS _____ **AGE** _____
Street Apt.#

_____ **HOME PHONE** _____
City State Zip Area Code Number

CELL PHONE _____ **SEX** Male / Female **MARITAL STATUS** Single / Married / Divorced / Widowed

SOCIAL SECURITY NUMBER _____ **DATE OF BIRTH** _____ / _____ / _____
Month Day Year

REFERRING PHYSICIAN? _____

PRIMARY CARE PHYSICIAN _____

EMPLOYER _____
Name City/State Phone number

SPOUSE/ PARENT /GUARDIAN _____ **DATE OF BIRTH** _____ / _____ / _____
Month Day Year

SOCIAL SECURITY NUMBER _____

SPOUSE/PARENT/GUARDIAN EMPLOYER _____
Phone Number

EMERGENCY CONTACT _____
Name Phone Number

PLEASE PRESENT INSURANCE CARDS OR OTHER DOCUMENTS TO RECEPTIONIST FOR COPYING

NAME OF POLICY HOLDER(if other than patient) _____

RELATIONSHIP TO POLICY HOLDER Self / Spouse / Child **POLICY HOLDER DATE OF BIRTH** _____

POLICY HOLDER SS# _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims. You authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Signature of patient or legal guardian

Date

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine at home?	Yes / No
Leave a message at your place of employment?	Yes / No
Discuss your medical condition with any member of your household?	Yes / No

IF YES, WHOM? _____ **RELATIONSHIP** _____

I HAVE REVIEWED DR. HERRON'S HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature

Date