Patient Registration Form

Please complete this form in its entirety.

Date: __________ Referred by: ____________________________

Name: ____
(Last) (Middle Initial) (First)

Address: ____

City: ___________________________ State: _____________ Zip: ____________

Home Phone: ______________________ Cell Phone: _____________________

Date of Birth: ______________________ S.S. Number_____________________

E-Mail Address: ____

2nd Address: ____

City: __________________________ State: ____ Zip: _________

Phone: _________________________________

Emergency Contact: ____
(Name) (Phone)

Do we have your permission to leave appointment reminders on your answering machine?

Yes: _______________ No: ___________________

MEDICARE AND CIGNA ARE WITHIN NETWORK

ALL OTHER INSURANCES ARE CONSIDERED OUT OF NETWORK

Payment is expected at the time of service. You will be reimbursed directly by the insurance company as we are not contracted with your plan. Reimbursement is based on your out of networks benefits. Responsibility for all charges, fees and services rendered are that of the patient. A corresponding fee will be incurred for any returned checks.

Your signature below signifies your understanding and agreement with our policies.

____________________________________ Date: _______________________
(Signature)