PATIENT REGISTRATION

Name_____ Birth Date _____

Address_____

City_____ State_____ Zip Code _____

SS#_____-_____-_____ Home Phone_____ Sex M ☐ F ☐

Marital Status M ☐ S ☐ D ☐ Name of Spouse_____

Emergency Contact_____ Phone_____

Address_____

Patient's Employer_____ Occupation_____

Street Address_____ Phone_____

Guarantor Information(Person responsible for payment of account **if patient is a minor or other than above**)

Name_____ Birth Date_____

Address_____

City_____ State_____ Zip Code_____

SS#_____-_____-_____ Home Phone_____ Sex M ☐ F ☐

Employer_____Occupation_____

Street Address_____ Phone_____

Insurance Coverage: YES ☐ NO ☐

AUTHORIZATION STATEMENT

I authorize the release of any medical information, including related psychiatric care, drug and alcohol abuse, and AIDS/HIV confidential information, necessary to process insurance claims. This signature on file may also be used for medical record(s) release and transfer to this facility. I permit a copy of this authorization to be used in place of the original. I understand and agree that I am responsible for payment of all charges, regardless of insurance coverage, and/or Medicare patients. I agree to accept full responsibility for charges that are not covered by insurance/Medicare providing that they are deemed necessary and I agree to have the services rendered in advance of this financial understanding.

Signed_____ Date_____

A. Significant health problems within your immediate family (mother, father, brothers, sisters):

_____

_____

_____

_____

B. Previous surgery and dates:

_____

_____

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_____

C. Medications you are presently taking:

_____

_____

_____

_____

D. Do you drink coffee / tea? YES ☐ NO ☐ If so, how much per day?_____
E. Do you drink alcoholic beverages? YES ☐ NO ☐ _____ per day
F. Do you smoke or chew tobacco products? YES ☐ NO ☐
How much per day?_____ For how long?_____
G. Do you use illegal drugs? YES ☐ NO ☐
Have you ever used illegal drugs? YES ☐ NO ☐
H. Are you allergic to any medications? YES ☐ NO ☐ *(please list any medications you're allergic to)*

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Patients Signature:_____ Date:_____