Patient Registration

Name: Soc. Sec. #

Street: Birthdate: Age:

City Home Phone: Cell phone:

Occupation (If minor, parent's occupation)

Employer:

Work address:

Insurance information

Do you have Medicare? Yes No (Please circle) Medicare number:

Do you have Medigap? Yes No (Please circle)

Primary insurance carrier:

Secondary Insurance Carrier

Do you have a prescription card? Yes No (Please Circle)

Name of family doctor: Phone number:

Name of pharmacy: Phone number:

Statement to authorize and release my medical record.

Last Name First Name Phone Number Signature

I hereby **give my permission for treatment** and I understand that payment **in full** is due at the time of service.

Patient's signature:

Parent/guardian's signature (If patient is minor):

May we use your medical records and/or photographs for the purpose of medical education? **Yes** **No**

I realize there will be no compensation. My signature below will authorize the above.

Signature: