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REGISTRATION FORM (PLEASE PRINT CLEARLY)

NAME: _____ BIRTH DATE: _____
LAST FIRST MIDDLE INITIAL

STREET: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RACE: _____ EMAIL: _____

ETHNICITY: _____ PHARMACY: _____

HOME TEL #: _____ CELL PHONE #: _____ DAYTIME TEL #: _____

MALE: _____ FEMALE: _____ LANGUAGE: _____ S.S. #: _____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____

TELEPHONE #: _____ RELATIONSHIP: _____

OCCUPATION: _____ EMPLOYER NAME: _____

EMPLOYER TELEPHONE #: _____

REFERRING PHYSICIAN'S NAME: _____

REFERRING PHYSICIAN'S ADDRESS: _____

REFERRING PHYSICIAN'S TELEPHONE #: _____

REPORT REQUESTED FOR REFERRING PHYSICIAN? YES_____ NO_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

INSURED'S NAME (IF NOT SAME AS ABOVE): _____

STREET: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT'S RELATIONSHIP TO INSURED (CIRCLE ONE): SELF SPOUSE CHILD OTHER

MEDICARE? YES_____ NO_____ IF YES, NUMBER _____

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

I authorize any holder of medical or other information about me to release to the Social Security administration and Health Care Financing Administrations or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments.

SIGNATURE: _____ DATE: _____

PAYMENT IS REQUESTED AT TIME OF VISIT