



REGISTRATION / INSURANCE VERIFICATION FORM

Name: _____

S.S. #: _____ D.O.B.: _____ Gender: Male Female

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Phone #: _____

Send Bill To (if different than above):

Name: _____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holders D.O.B.: _____

Employer: _____ Policy Holders S.S. #: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holders D.O.B.: _____

Employer: _____ Policy Holders S.S. #: _____

I authorize my physician to release to my insurance carrier(s) information and/or provide copies of any and all of my medical records, including billing information, history all diagnoses and information, including, but not limited to, psychiatric, HIV or HIV-related illness, the use of drugs or alcohol, for the purpose of obtaining payment for services rendered. I also authorize my insurance carrier(s) to make payment for these services to this office or its billing agent when assignment is accepted. I have completed this form fully and completely, and certify that I am the patient/guardian or an authorized general agent of the patient authorized to furnish this information. If I am the person authorizing this visit, it will ultimately be my responsibility for payment of services if not otherwise received.

Patient Signature: _____ Date: _____

Please provide us with how you were referred to our facility: _____