NEW PATIENT REGISTRATION

PATIENT

Name _____ (Title) _____ (First) _____ (Middle) _____ (Last) _____ (Suffix) _____ (Degree) _____ (Nickname)

Sex _____ Age _____ Birth Date _____ SS# _____ PTUID# _____

Address _____ (Line #1) _____ (City) _____ (State) _____ (Zip)

_____ (Line #2)

Phone Numbers _____ (Home) _____ (Cell) _____ (Work) _____ (Ext)

_____ (Other) _____ (FAX) _____ (Pager)

E-Mail _____ (Personal) _____ (Work)

Occupation _____ (Description) _____ (Occupation Code)

Driver's License _____ (Number) _____ (State) _____ (Expiration Date)

Employer _____ Employment Status Full time Part time Not employed Self Employed Retired Active Duty Unknown

Employer Address _____ (Line #1) _____ (City) _____ (State) _____ (Zip)

_____ (Line #2)

Marital Status | Married Single Widow(er) Divorced Separated Unknown

REGISTRATION CONTINUED _____ _____ _____
Name DOB Date

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby designate _____ to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-l(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee healthcare benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor.

These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

_____
Patient's Signature

Patient's Signature (Image)

_____
Patient's Printed Name

_____
Date

Patient's Signature (Image)

Patient's Signature (Image)

Patient's Signature (Image)