PATIENT REGISTRATION

NAME_____ DATE OF BIRTH_____ AGE_____

STREET ADDRESS_____ CITY_____

STATE____ ZIP CODE_____ HOME PHONE_____ CELL _____

FATHER'S NAME_____ DATE OF BIRTH_____

SS#_____ OCCUPATION_____

EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____ CITY_____

MOTHER"S NAME_____ DATE OF BIRTH_____

SS#_____ OCCUPATION_____

EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____ CITY_____

EMERGENCY CONTACT OTHER THAN PARENT_____ PHONE_____

CLOSEST RELATIVES NOT AT YOUR ADDRESS_____ PHONE_____

INSURANCE AND BILLING INFORMATION

CIRCLE PERSON RESPONSIBLE : FATHER MOTHER OTHER/ RELATIONSHIP_____

BILLING ADDRESS_____

PHONE_____

PAYMENT REQUIRED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

1) INSURANCE COMPANY_____ ADDRESS_____

SUBSCRIBER'S NAME_____ ID#_____ GROUP#_____

2)INSURANCE COMPANY_____ ADDRESS_____

SUBSCRIBER'S NAME_____ ID#_____ GROUP#_____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of medical benefits to Dr. Bharti Amin for services rendered by her. I understand that I am financially responsible for any Balance not covered by my insurance.

Patient name_____ date_____

Parent / guardian_____ signature_____