DATE: _____

PATIENT REGISTRATION FORM - *Please print legibly*

LAST NAME	FIRST NAME	M.I.	GENDER M F
ADDRESS	CITY	STATE	ZIP CODE

PRIMARY PHONE: (H) (W) (C) ( )	SECONDARY PHONE: (H) (W) (C) ( )	TERCIARY PHONE: (H) (W) (C) ( )
DATE OF BIRTH / AGE	SOCIAL SECURITY # - -	MARITAL STATUS OF PATIENT: M S O
IF PATIENT IS UNDER 18- PARENT/GUARDIAN:	RELATIONSHIP TO PATIENT:	
EMERGENCY CONTACT (AUTHORIZED FOR HIPPA)	RELATIONSHIP TO PATIENT	PHONE # (H) (W) (C) ( )
PATIENT/PARENT/GUARDIAN & OCCUPATION	PLACE OF EMPLOYMENT / ADDRESS	
NAME OF SPOUSE & OCCUPATION	SPOUSE'S EMPLOYER / ADDRESS	SPOUSE'S CONTACT NUMBER (H) (W) (C) ( )
REASON FOR CONSULTATION/ VISIT		

REFERRING PHYSICIAN: _____	PRIMARY CARE (OR) PEDIATRICIAN: _____
SPECIALTY: _____	ADDRESS: _____
ADDRESS:_____	_____
PHONE: ( )	PHONE: ( )

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE POLICY AND BENEFITS.
CURRENT INSURANCE CARD AND OFFICIAL PHOTO IDENTIFICATION MUST BE PRESENTED AT EVERY APPOINTMENT.

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
POLICY/GROUP#	NAME OF SUBSCRIBER	POLICY/GROUP#	NAME OF SUBSCRIBER
SUBSCRIBER RELATIONSHIP TO PATIENT		SUBSCRIBER RELATIONSHIP TO PATIENT	

PRESCRIPTION REFILLS: PLEASE CALL YOUR PHARMACY TO FAX A REQUEST TO THE PHYSICIAN. ALLOW 24-48 HOURS FOR PROCESSING.

Pharmacy Name: _____ **Pharmacy Number: (_____)**_____

EMAIL CONTACT INFORMATION: FOR MEDICAL UPDATES AND IN CASE OF AN EMERGENCY, PLEASE LIST YOUR EMAIL ADDRESS BELOW.

Email Address: _____

ASSIGNMENT OF BENEFITS - CONSENT FOR TREATMENT - RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other plan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize Dr. Albert J. Nemeth to release all information necessary to secure payment. I hereby authorize Albert J. Nemeth, M.D., P.A. to perform any medical treatment as deemed necessary.

_____ _____

Signature of Patient/Legal Guardian **Date**