

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) ()		TERTIARY PHONE: (H) (W) (C) ()	
DATE OF BIRTH		AGE		MARITAL STATUS OF PATIENT: M S O	
IF PATIENT IS UNDER 18- PARENT/GUARDIAN:			RELATIONSHIP TO PATIENT:		
EMERGENCY CONTACT (AUTHORIZED FOR HIPAA)		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