Patient:

DOB:

Date:

ADULT REGISTRATION FORM (19 years of age and older)

Address apt # City State Zip

( ) _____ ( ) _____

Home phone Cell or alternate phone

OK to leave message on phone? ☐ Yes ☐ No

_____ / / _____ / /

SELF: Name/Social Security # date of birth Spouse: Name/Social Security # date of birth

_____ _____

E-mail Employer

_____

Employer

PRIMARY Insurance Company _____ Subscriber Name _____

Subscriber address (if different from above) _____

_____

Subscriber's birthdate ____/____/____ (required for insurance billing)

SECONDARY Insurance Company _____ Subscriber Name _____

Subscriber's birthdate ____/____/____ (required for insurance billing)

VSP ☐ Yes ☐ No Subscribers last 4 digits of ss# _____

_____ _____

Primary Care Doctor phone Referring Doctor phone

_____ _____

address address

Office visit claims are submitted to insurance companies based soley on the diagnosis and exam performed by the physician. We cannot change billing for the purpose of maximizing insurance payment and/or minimizing patient financial responsibility. I hereby authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances. Should the account be referred for collections, the undersigned, or their agent will be responsible for payment of collection fees, and court costs. **There is a $25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

_____

Signature of responsible party date