PATIENT REGISTRATION

PATIENT INFORMATION

Name____
Last First M.I.

Address____
City State Zip

Home Phone_______________________ Cell Phone___________________________

Employer__________________________ Work Phone__________________________

Preferred contact:( )home ( )cell ( )work Email address_______________________

Other person(s) who may receive your medical information (e.g. biopsy reports, etc):
____

Date of Birth ___/___/___ Age___ Gender___ Social Security #__________________

Marital Status____ Emergency contact______________________________________

Other family members that are patients:_______________________________________

Referred by:______________________ Primary Care Physician___________________

Pharmacy name/phone number:____

Parent/Guardian (if child):_________________________ Relationship______________

PRIVACY RELEASE
I authorize the release of medical information to my primary care or referring physician, to consultants and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

PLEASE CHECK ONE: I ___request ____defer a full copy of the privacy notice.

FINANCIAL POLICY AND CANCELLATION POLICY
Payment is due at time of service unless you have a health insurance plan in which we participate; for those patients, copays and deductibles will be collected. You will be responsible for any balance not covered by the insurance. You are also responsible for knowing your deductible and whether or not it has been met. We accept payment in the form of cash, check, and credit card. Patients without insurance must pay by cash or credit card. Returned check fees are $25. We require 24 hour notice for cancellations or you will be charged $25. A $50 fee is charged for cancelled surgeries. We reserve the right to discharge patients for frequent no-shows and last minute cancellations or failure to pay. Your signature below signifies your understanding with this policy.

Patient or Guardian________________________________ Date_________________