PATIENT REGISTRATION/UPDATE FORM

Name (First/M./Last)____ Date _______________

Gender (circle): M F Birth Date_______________ Marital Status (circle): Married Divorced Single

SSN ____________________ Driver's License Number__________________ Expiration Date_______________

Address (No P.O. Boxes) ____

City____State_________________Zip__________________

Mailing Address (if different from above) ____

City____ State________________ Zip___________________

Home Phone____________________ Work Phone____________________ Cell Phone____________________

Preferred Method of Contact (Circle): Home Phone Work Phone Cell Phone Email Mail

Preferred Language ___________________________________ Email__________________________________

Race (circle): American Indian/Alaska Native Asian Black/American African

Caucasian Hispanic Indian Middle Eastern Native Hawaiian/Polynesian

Ethnicity (circle): Hispanic/Latino Native Hawaiian/Polynesian Not Hispanic or Latino

Were you referred by your doctor? Y N Doctor's Name ____

How did you choose us? ____

Employer_______________________________________ Occupation__________________________________

Address ____

City ____ State____________________ Zip__________________

EMERGENCY CONTACT INFORMATION

Name (First/M./Last)____ Relationship ________________

Home Phone ___________________ Work Phone ___________________ Cell Phone ____________________

Alternate Contact Name (First/M./Last) ______________________________ Relationship ________________

Home Phone ___________________ Work Phone ___________________ Cell Phone ____________________

INSURANCE INFORMATION

Who is responsible for this account? (First/M./Last) ____

Birth Date _________________________________ Relationship to Patient_____________________________

Insurance Company _______________________________________ Group Number _____________________

Address ____

City_______________________________________ State_____________________ Zip ___________________

Additional Insurance (i.e. Major Medical) ____

Subscriber Name ____Birth Date ___________

Relationship to Patient ___________________________ SSN ____

Insurance Company _______________________________________ Group Number _____________________

Address ____

City_______________________________________ State ____________________ Zip ___________________

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Dr. John Fagan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____ Date ___________________

Print Name ____ Relationship to Patient ____________