PATIENT REGISTRATION FORM

PATIENT

Last Name	First	MI	❑ Male ❑ Female	Marital Status
Address	City	St	Zip	
Home Phone	Cell Phone	Work Phone	Language Preference	
Social Security	Date of Birth	Email Address		
Employer	Employment Status: (circle one) Full-time Part-time Other:________________	Occupation		
Employer Address	City	St	Zip	
Emergency Contact **NAME, PHONE, RELATIONSHIP**	Primary Care Physician			

RESPONSIBLE PARTY

Last Name	First	MI	❑ Male ❑ Female	Marital Status
Address (if different)	City	St	Zip	
Home Phone	Cell Phone	Work Phone	Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other:___________________	
Social Security	Date of Birth			
Employer	Employment Status: (circle one) Full-time Part-time Other:________________	Occupation		
Employer Address	City	St	Zip	

PRIMARY INSURANCE

Primary Insurance Name	Relationship to Patient	Occupation	
Insurance Policy Holder's Name (if different)	Insurance ID Number	Insurance Group Number	
Social Security Number	Birth Date	Primary Phone	Work Phone
Employer	Employer Phone	Employment Status (circle one): Full-time Part-time Other:_________	
Employer Address	City	State	Zip

SECONDARY INSURANCE

Secondary Insurance Name	Relationship to Patient	Occupation	
Insurance Policy Holder's Name (if different)	Insurance ID Number	Insurance Group Number	
Social Security Number	Birth Date	Primary Phone	Work Phone
Employer	Employer Phone	Employment Status (circle one): Full-time Part-time Other:_________	
Employer Address	City	State	Zip

OFFICE POLICY: I understand and agree to the following rules set forth by Renown Health:

1) Payment is required at the time of service. If I cannot pay my co-payment, my appointment will be rescheduled.
2) If I am more than 15 minutes late for an appointment, my appointment will be rescheduled.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines proper. I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original). I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

Signature: ____________________ Date: __________