Patient Registration Information

*Please **PRINT** AND complete ALL sections below!*

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (First Name) _____ (Middle initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (Last Name) _____ (First Name) _____ (Middle initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

PRIMARY Insurance Name: _____

Insurance Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ SPEC Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ SPEC Copay: $ _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr Myatt. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be as valid as the original. A notice of Privacy Practices describing my rights under HIPAA Law and the uses and disclosures of my proctected health information has been made available to me.

Date : _____ Your Signature: _____