

# New Patient Registration

## Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
First MI Last

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

I prefer to receive calls at: (check)  Home  Work  Cell/Other I am: (check)  under Age18

Marital Status: (check)  Single  Married  Divorced  Widowed  Separated  Domestic Partner

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

Referred by: (check)  Physician  Friend  Website  Other

## Payment Information

Person Responsible for Payment: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Insurance Information

Do you have health insurance? ____ Yes ____ No	
Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:
<b>Please have your insurance card and driver's license ready so they can be copied for the clinic's records.</b>	

## Consent for Treatment

**Assignment & Release** - By signing below, I authorize Dr. Polsky/Dr. Sharpe to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr. Polsky/Dr. Sharpe and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_