

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI _____ Nickname: _____
 Date of Birth: ____/____/____ Sex: M F Social Security #: ____ - ____ - ____ Race: _____
 Marital Status: S M W D Primary Language: _____ Religion: _____
 Street: _____ City: _____ State: ____ Zip: _____
 Home Phone #: (____) ____ - ____ Work Phone #: (____) ____ - ____ Cell Phone #: (____) ____ - ____
 Primary Phone #: (____) ____ - ____ E-Mail Address: _____
 Person to Notify in Case of an Emergency: _____
 Relationship: _____ Home Phone #: (____) ____ - ____ Cell Phone #: (____) ____ - ____
 Preferred Pharmacy: Name _____ Location _____ Phone # _____

Responsible Party (If patient is a minor, person who brought minor to the office)

Last Name: _____ First Name _____ MI _____ Nickname: _____
 Date of Birth: ____/____/____ Sex: M F Social Security #: ____ - ____ - ____ Race: _____
 Marital Status: S M W D Primary Language: _____ Religion: _____
 Street: _____ City: _____ State: ____ Zip: _____
 Home Phone #: (____) ____ - ____ Work Phone #: (____) ____ - ____ Cell Phone #: (____) ____ - ____
 Primary Phone #: (____) ____ - ____ E-Mail Address: _____
 Relationship to Patient: Self Parent Spouse Other _____

Insured Person Information (If different than patient information)

Last Name: _____ First Name _____ MI _____ Nickname: _____
 Date of Birth: ____/____/____ Sex: M F Social Security #: ____ - ____ - ____ Race: _____
 Marital Status: S M W D Primary Language: _____ Religion: _____
 Street: _____ City: _____ State: ____ Zip: _____
 Home Phone #: (____) ____ - ____ Work Phone #: (____) ____ - ____ Cell Phone #: (____) ____ - ____
 Primary Phone #: (____) ____ - ____ E-Mail Address: _____
 Relationship to Patient: Self Parent Spouse Other _____

Assignment and Release

My signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize payment of medical benefits to the doctor when an assigned claim is filed. I authorize that any benefits due to me be paid directly to the physician. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given). By signing this form, I acknowledge that I have received ACDA's Financial Policy and am aware that it can change at any time.

Patient Signature

Parent Signature (if patient is a minor)

Date