PATIENT REGISTRATION

DATE: _____

PATIENT INFORMATION

Name: _____ Social Security #:_____
Last First MI

Address: _____ City: _____ Zip: _____

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

Gender: _____ Age: _____ DOB: _____

Relationship Status: Single Partnered Married Divorced Separated Widowed

Occupation: _____ Name of Employer: _____

Student Status: Full time Part time School Attending: _____

How were you referred to our practice? _____

In the event of an emergency, please notify: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE

Name of Carrier: _____

Member ID or Subscriber #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

SECONDARY INSURANCE

Name of Carrier: _____

Member ID or Subscriber #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

NOTIFICATION AND CANCELLATION POLICY

We ask that you give our office 24 hours' notification if you need to cancel your appointment. We reserve the right to charge for missed appointments or appointments not cancelled with 24 hours' notice. If a new patient appointment is missed, it will not be rescheduled.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed carrier and assign directly to COBM, Inc. all the 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 provider 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: _____