Patient Registration Form

Patient's Name: _____

Date of Birth___/___/_____ Age: _____ Sex: F [ ] M [ ] Social Security Number: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Cell: ( ) _____Home: ( ) _____Work: ( ) _____

Email: _____

Marital Status: Married (__) Single (__) Divorced (__) Widowed (__)

Referred by: _____

Release of information:

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s):_____ **Relationship to patient**: _____

Insurance Information:

Primary Insurance: _____ Effective Date: ___/____/___

Secondary Insurance (If any): _____Effective Date: ___/____/___

Guarantors Name: (If other than self) _____D.O.B__/___/___

Address: _____City: _____State: ____ Zip: _____

Social Security Number: _____ Phone: ( ) _____

Relationship to Patient: _____

Emergency Contact:

Name _____Relationship to Patient: _____

Phone Number: _____

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White/Caucasian [ ] Hispanic or Latino [ ] Other: _____

Ethnicity**:** Do you identify with an Ethnic origin? If yes, please note: _____

Preferred Pharmacy: _____

Any Allergies to Medication or Food (list reactions): _____

_____

I hereby authorize Dr. Howard Zahalsky to bill my insurance company and receive payments from them on my behalf. Dr. Zahalsky may release my medical information to my insurance company in the processing of claims. I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered.

_____ _____

Signature of Patient or Guardian/POA **Date**