Name	Date	(PLEASE PRINT)	Home Phone ()
Address	– Patient Information –		
Address	Name Last Name Rivs	t Name Middle Initial	SS/HIC/Patient ID #
State			Cell Phone (
Sex   M   F Age   Birthdate   Geparated   Divorced   Partnered for years   Patient Employer/School   Occupation   Employer/School Address   Employer/School Phone ( )   Employer/School Address   Employer/School Phone ( )   Whom may we thank for referring you?   Phone ( )   In case of emergency who should be notified?   Phone ( )    - Primary Insurance -  Person Responsible for Account   Last Name   Birthdate   Soc. Sec. #   Address (if different from patient's)   Phone ( )   Ensurance Company   State   Zip   Ensurance Company   Subscriber #   Ensurance Company   Subscriber   Birthdate   Ensurance   Ensurance Company   Subscriber   Ensurance   Ensurance   Ensurance   Ensurance Company   Ensurance   Ensurance			
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Employer/School Address	-	☐ Separated	☐ Divorced ☐ Partnered for years
Norm may we thank for referring you?  In case of emergency who should be notified?  Phone ()  Person Responsible for Account Last Name Pirst Name Pirst Name Middle Initial Relation to Patient from patient's) Phone ()  CityStateZip			
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Person Responsible for Account Last Name Pirst Name Middle Initial Relation to Patient Soc. Sec. # Middle Initial Relation to Patient Soc. Sec. # Phone ()  City State Zip  Person Responsible Employed by Occupation Business Address Business Phone ()  Insurance Company  Contract # Group # Subscriber #  Names of other dependents covered under this plan  Fadditional Insurance Omegany  Subscriber #  Subscriber Mame Relation to Patient Birthdate Birthdate Birthdate  Address (If different from patient's) Phone ()  City State Zip  Subscriber Employed by Business Phone ()			
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Person Responsible for Account Last Name Birthdate Soc. Sec. #  Address (If different from patient's) City State City Person Responsible Employed by Occupation Business Address Business Phone () Insurance Company Contract # Group # Subscriber #  Names of other dependents covered under this plan  First Name Relation to Patient Birthdate Birthdate Birthdate Birthdate Birthdate Birthdate Birthdate Address (If different from patient's) Subscriber Name Relation to Patient Birthdate Bi		Primary Insuranc	e –
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Subscriber Name Relation to Patient Birthdate  Address (If different from patient's) Phone ()  City State Zip  Subscriber Employed by Business Phone ()	<i>– 1</i>	Additional Insuran	ce –
Address (If different from patient's)       Phone ()         City       State       Zip         Subscriber Employed by       Business Phone ()	E1 (251)		
City         State         Zip           Subscriber Employed by         Business Phone ()			
Subscriber Employed by Business Phone ()			**************************************
Insurance Company Soc. Sec. #			
Contract # Subscriber #			Subscriber #
Names of other dependents covered under this plan	Names of other dependents covered under this plan.		THE RESERVE THE PROPERTY OF SHARE
<ul> <li>Assignment and Release –</li> </ul>			
I certify that I, and/or my dependent(s), have insurance coverage with and Name of Insurance Company(ies)			
assign directly to Dr all 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 authorize the use of my signature on all insurance submissions.			
The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.			
Signature of Patient, Parent, Guardian or Personal Representative Date	Signature of Patient, Parent, Guardian	n or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient	Please print name of Patient, Parent, Guar	rdian or Personal Representative	Relationship to Patient

Registration Form –