

**PATIENT REGISTRATION FORM**

<b>HOW DID YOU HEAR ABOUT US?</b>				<b>NICKNAME</b>	
<b>PATIENT'S FULL NAME</b>				<b>MAIDEN NAME</b>	
<b>PHYSICAL ADDRESS</b>			<b>APT. NO.</b>	<b>HOME NUMBER</b>	
				May we leave detailed messages? (Yes) (No)	
<b>CITY</b>	<b>STATE</b>		<b>ZIP</b>	<b>BUSINESS PHONE</b>	
				May we leave detailed messages? (Yes) (No)	
<b>GENDER:</b>	<input type="checkbox"/> F <input type="checkbox"/> M	<b>MARITAL STATUS</b>	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	<b>DATE OF BIRTH</b>
					<b>CELL PHONE</b>
					May we leave detailed messages? (Yes) (No)
<b>EMPLOYMENT STATUS</b>			<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER <input type="checkbox"/> STUDENT		<b>PATIENT'S SOCIALSECURITY</b>
<b>PATIENT'S EMPLOYER NAME</b>			<b>PATIENT'S EMAIL ADDRESS</b>		
<b>EMPLOYER'S ADDRESS</b>					
<b>SPOUSE/GUARDIAN NAME</b>			<b>PHONE #</b>	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY</b>
<b>SPOUSE'S EMPLOYER</b>			<b>ADDRESS</b>		
<b>IN CASE OF EMERGENCY CONTACT</b>			<b>RELATIONSHIP</b>		<b>PHONE NUMBER</b>
<b>PRIMARY INSURANCE COVERAGE</b>					
<b>NAME OF INSURED</b>			<b>INSURED DOB</b>	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
<b>INSURED'S EMPLOYER</b>			<b>WORK PHONE:</b>		
<b>EMPLOYER ADDRESS</b>					
<b>INSURANCE COMPANY</b>			<b>CO-PAY AMOUNT</b>	<b>CO-INSURANCE %</b>	
<b>INSURANCE CLAIMS ADDRESS</b>			<b>INSURANCE PHONE NO.</b>		
<b>CITY</b>	<b>STATE</b>		<b>ZIP</b>		
<b>POLICY NUMBER</b>	<b>GROUP NUMBER</b>	<b>INSURED'S SOCIAL SECURITY</b>			
<b>SECONDARY INSURANCE COVERAGE</b>					
<b>NAME OF INSURED</b>			<b>INSURED DOB</b>	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	
<b>INSURED'S EMPLOYER</b>			<b>WORK PHONE</b>		
<b>EMPLOYER ADDRESS</b>					
<b>INSURANCE COMPANY</b>			<b>CO-PAY AMOUNT</b>	<b>CO-INSURANCE %</b>	
<b>INSURANCE CLAIMS ADDRESS</b>			<b>INSURANCE PHONE NO.</b>		
<b>CITY</b>	<b>STATE</b>		<b>ZIP</b>		
<b>POLICY NUMBER</b>	<b>GROUP NUMBER</b>	<b>INSURED'S SOCIAL SECURITY</b>			

**CONSENT FOR TREATMENT, INSURANCE AUTHORIZATION AND ASSIGNMENT**

I authorize Complete Family Practice & Sports Medicine and its provider(s) to render all necessary medical care and treatment to me or my dependent (child or other). I also authorize the physician, based on his/her discretion, to access my chart for managing my (or my dependent's) health care. I further authorize Complete Family Practice & Sports Medicine to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Complete Family Practice & Sports Medicine and the provider. I understand that I am ultimately responsible for all services whether covered by my insurance company or not. I understand that my co-payment, co-insurance, or fee for service, is due at the time of service. I also understand that if my deductible has not been met at the time of service, I will be responsible for such amounts up to the fee for service.

**Date:** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_