YOUR LIFE – YOUR HEALTH
OUR CONCERN

Patient Registration

Today's Date: ____________________ Gender: ____ Male ____ Female

Patient Name: __________________________ Date of Birth: ______________________

Address: ____
Street City State Zip Code

Name of Parent or Guardian (minors): ____

Home Phone #: _________________________ Cell Phone #: _________________________

Email: ________________________________ Social Security #: ______ - ______ - ______

Marital Status (circle one): Married Divorced Widowed Single

Emergency Contact

Contact Name: _________________________ Phone #: _______________________________

Alt. Phone #: ___________________________ Relationship: ___________________________

Insurance Information

Insurance Company: _____________________ Policy Holder: ____________________

Member ID: ____________________________ Group #: ________________________

If patient is not the policy holder, please provide the following:

Policy Holder's Date of Birth: ______________ Policy Holder SSN #: ______ - ______ - ______

Authorization of Disclosure of Information

I ______________________________, the patient, authorize the full disclosure of my entire medical record including but not limited to patient histories, office notes, test results, radiology studies, films, consults, alcohol/drug treatment, mental health information, HIV-related information, billing records, insurance records, and records sent by other physicians to the following individual(s).

Name of Individual	Relationship to patient	Contact number
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I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of the disclosure. Information re-disclosed by the recipients listed in this authorization will not be the liability of the physicians. Authorization maybe be revoked in part or in full at any time with a written or verbal authorization by the patient.

______________________	X______________________	______________________
Printed Patient Name	Patient Signature	Date