

****Please review and update the information below to the best of your ability.****

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
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Last Name:
 First Name:
 Middle Name:
 Address:
 City: State:
 Zip:
 Home Phone:
 Work Phone:
 Mobile Phone:
 Sex: **F**
 Date of Birth:
 Social Security No.:
 Patient email:
 Required by government mandate [although you may refuse]:
 Language:
 Race:
 Ethnicity:
 Marital Status:

Name:
 Address:
 Relationship to patient: _____
 Date of Birth:
 Social Security No.:
 Phone: () _____ - _____

Emergency Contact Information

Name:
 Relationship:
 Phone:
 Mobile Phone:() _____ - _____

Employer information

Employer:
 Address:
 Phone:

Other

Patient Referred by:
 Primary Care Provider:
 Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:
 Crossroads:
 Phone:

Primary Insurance Information

Insurance Plan Name:
 Last Name:
 First Name:
 Middle Name:
 Address:
 City: State: Zip:
 Date of Birth: Sex (please circle): **M** or **F**
 Employer Name:
 Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
 Last Name:
 First Name.:
 Middle Name:
 Address:
 City: State: Zip:
 Date of Birth: Sex (please circle): **M** or **F**
 Employer Name:
 Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed _____ **Date:** _____

****Please sign and date each item below****

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for

Signed _____ Date: _____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed _____ Date: _____

- I authorize to release medical information required to process my claim

Signed _____ Date: _____

- I have read and understand the Financial Policy for

Signed _____ Date: _____

- I authorize to obtain/have access to my medication history

Signed _____ Date: _____

- I authorize my provider's office to contact me by mobile phone

Signed _____ Date: _____