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Patient Registration		
Patient name:	DOB:	Age:
Social Security #:	Marital Status:	
Home Address		
City:	State:	Zip code:
Cell Phone:	Email:	
Occupation:	Employer:	
Work phone:		
Primary language spoke:	Referred by:	
Emergency Contact:		
Cell Number:		
Primary Care Physician:		
Allergies to medications:		
Pharmacy name, address and phone number:		
INSURANCE INFORMATION		
Name of Primary Insurance:		
Provider Number/Customer Service number:		
Member ID:	Group number:	
Claims address (PO Box):		
Name of Subscriber:	DOB:	Relation to patient:
RELEASE OF INFORMATION/ENTREGA DE INFORMACION		
I authorize the release of any medical information necessary to process a claim.		
Signed:	Date:	
ASSIGNMENT OF BENEFITS		
I authorize payment of Medical benefits to myself or the name of the professional services rendered.		
Signed:	Date:	