# PATIENT REGISTRATION FORM

## Patient Information

Name:_____Birthdate:____-____-____

SS#:_____-____-_____ Age:____ Sex: M or F Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: : ( )_____

Email Address: _____ Occupation:_____

Employer:_____ Address:_____ Phone: ( )_____

Emergency Contact:_____ Relationship:_____Phone: ( )_____

Primary Care Physician:_____

Address:_____ Phone: ( )_____

Referring Physician:_____

Address:_____ Phone: ( )_____

Preferred Pharmacy:_____ Phone: ( )_____ Zip Code_____

## Insurance Subscriber Information (If other than patient)

Name:_____Birthdate:____-____-____

SS#:_____-____-_____ Age:_____ Sex: M or F Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____Occupation:_____

Employer:_____ Address:_____ Phone: ( )_____

Relationship to Patient:_____

## Patients under Age 18

Mother's Name:_____ SS#:_____ -_____ -_____

Home Phone: ( )_____ Work Phone: ( )_____

Father's Name:_____ SS#:_____ -_____ -_____

Home Phone: ( )_____ Work Phone: ( )_____

## Auto/Workers Compensation Claims (Please Circle)

Was this the result of an accident or injury? Yes No Type of Claim: WC Auto Worker Comp/Auto Claim #:_____

Date of Accident or Injury: _____Place of Accident or Injury (include state if auto):_____

Injury Description:_____

Are you presently working? Yes No If no, last date worked:_____

Insurance Name:_____Phone: ( )_____

Contact Person/Agents Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Responsible Employer (Workers Comp Only):_____ Phone: ( )_____

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Robert C Arffa, MD. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Robert C Arffa, MD to release all information necessary to secure the payment.

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**

Signed:_____ Date:_____