

**PATIENT REGISTRATION FORM**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_  
City State Zip Home Phone #

Patient's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security # \_\_\_\_\_

Other Children: Names: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_

**PARENT INFORMATION**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Father's Cell # \_\_\_\_\_ DOB: \_\_\_\_\_ Mother's Cell # \_\_\_\_\_

Social Security #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_  
City State Zip Phone #

Person responsible for payment \_\_\_\_\_ Closest relative and phone # \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary Doctor (Circle One) Dr. Schorlemer Dr. Hieber Dr. Burns  
Dr. Hanig Dr. Shinn Dr. Fernandez

**\*PAYMENT IS EXPECTED AT TIME OF SERVICE\***

**INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I authorize payment to the physician for insurance claims.

X \_\_\_\_\_

I agree to promptly remit any co-payments and balances that my insurance denies.

X \_\_\_\_\_