# PATIENT REGISTRATION FORM

**PATIENT**

| | | | | |
|---|---|---|---|---|
| Last Name | First | MI | ❑ Male ❑ Female | Marital Status |
| Address | City | | St | Zip |
| Home Phone | Cell Phone | Work Phone | Language Preference | |
| Social Security | Date of Birth | Email Address | | |
| Employer | Employment Status: (circle one) Full-time Part-time Other:_____ | | Occupation | |
| Employer Address | City | | St | Zip |
| Emergency Contact **NAME, PHONE, RELATIONSHIP** | | | Primary Care Physician | |

**RESPONSIBLE PARTY**

| | | | | |
|---|---|---|---|---|
| Last Name | First | MI | ❑ Male ❑ Female | Marital Status |
| Address (if different) | City | | St | Zip |
| Home Phone | Cell Phone | Work Phone | Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other:_____ | |
| Social Security | Date of Birth | | | |
| Employer | Employment Status: (circle one) Full-time Part-time Other:_____ | | Occupation | |
| Employer Address | City | | St | Zip |

**PRIMARY INSURANCE**

| | | | |
|---|---|---|---|
| **Primary Insurance Name** | Relationship to Patient | | Occupation |
| Insurance Policy Holder's Name (if different) | Insurance ID Number | | Insurance Group Number |
| Social Security Number | Birth Date | Primary Phone | Work Phone |
| Employer | Employer Phone | Employment Status (circle one): Full-time Part-time Other:_____ | |
| Employer Address | City | State | Zip |

**SECONDARY INSURANCE**

| | | | |
|---|---|---|---|
| **Secondary Insurance Name** | Relationship to Patient | | Occupation |
| Insurance Policy Holder's Name (if different) | Insurance ID Number | | Insurance Group Number |
| Social Security Number | Birth Date | Primary Phone | Work Phone |
| Employer | Employer Phone | Employment Status (circle one): Full-time Part-time Other:_____ | |
| Employer Address | City | State | Zip |

**OFFICE POLICY: I understand and agree to the following rules set forth by Renown Health:**

1) Payment is required at the time of service. If I cannot pay my co-payment, my appointment will be rescheduled.

2) If I am more than 15 minutes late for an appointment, my appointment will be rescheduled.

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:**

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines proper. I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original). I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

Signature: _____ Date: _____