# PATIENT REGISTRATION

PATIENT'S NAME _____ DATE OF BIRTH _____

PURPOSE OF THIS APPOINTMENT _____

WHOM MAY WE THANK FOR REFERRING YOU _____
Name Address

(A) NAME OF RESPONSIBLE PARTY _____
Last First Middle

ADDRESS _____
Street City State Zip

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

PHONE (HOME) _____ PHONE (WORK) _____

NAME OF EMPLOYER _____

ADDRESS _____
Street City State Zip

(A) NAME OF SPOUSE _____
Last First Middle

ADDRESS (If different than above) _____
Street City State Zip

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

PHONE (HOME) _____ PHONE (WORK) _____

NAME OF EMPLOYER _____

ADDRESS _____
Street City State Zip

OTHER DEPENDENTS (C) _____ _____
Last First Date of Birth

(D) _____ _____

(E) _____ _____

(F) _____ _____

_____ _____
Date Signature (Patient or Parent/Guardian)

# INSURANCE INFORMATION

**INSURANCE (I)** *(Whose name is the insurance under)*

_____

NAME OF INSURANCE COMPANY _____ PHONE _____

ADDRESS _____
Street City State Zip

_____
Policy No. Group No.

FAMILY MEMBERS COVERED BY THIS POLICY _____

**INSURANCE (II)** *(If covered by spouse's or other parent) (Whose name is the insurance under)*

_____

NAME OF INSURANCE COMPANY _____ PHONE _____

ADDRESS _____
Street City State Zip

_____
Policy No. Group No.

FAMILY MEMBERS COVERED BY THIS POLICY _____

## RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE RELEASE OF ALL INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL ASSIGNMENT. I ASSIGN TO DR. BRILOWSKI AND ASSOCIATION ANY BENEFITS I AM ENTITLED FROM MY INSURANCE COMPANY FOR SERVICES PROVIDED AND UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF TYPE OR LEVEL OF INSURANCE COVERAGE.