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PATIENT REGISTRATION
PLEASE PRINT

NAME _____

DATE _____

AGE _____ DATE OF BIRTH _____

SOC.SEC.# _____

ADDRESS _____

MALE ___ FEMALE ___

CITY & STATE _____ ZIP _____

MARRIED ___ SINGLE ___

HOME PHONE _____ WORK

PHONE _____

EMPLOYER _____ ADDRESS _____

PARENT OR SPOUSE'S

NAME _____

PARENT OR SPOUSE'S

EMPLOYER _____ WORK

PHONE _____

INSURANCE INFORMATION
(PLEASE PRESENT CARD SO WE CAN COPY)

INSURANCE _____

ID# _____

ADDRESS _____

GROUP# _____

SUBSCRIBER _____

PERSON LEGALLY RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT):

NAME _____ PHONE _____

ADDRESS _____

WHO REFERRED YOU TO OUR OFFICE?

PRIMARY PHYSICIAN _____

IN CASE OF EMERGENCY

CONTACT _____ PHONE _____

_____ RELATIONSHIP _____

ALLERGIC TO WHAT MEDICATIONS?

LIST ALL MEDICATIONS TAKEN IN THE LAST

MONTH _____

Authorization And Signature
(Read, sign and date)

I agree to pay all charges for treatment promptly regardless of delays in insurance payment or denial of coverage. I authorize release of information to insurance companies and payment of insurance benefits to Dr. Webb. A copy of Notice of Privacy Practices has been available to me.

Signature _____

Date _____