PATIENT REGISTRATION

PATIENT SHOULD COMPLETE WHITE AREAS ONLY

PATIENT INFORMATION

PATIENT NUMBER											
LAST NAME				FIRST NAME & INITIAL							
ADDRESS LINE 1											
ADDRESS LINE 2											
CITY						STATE		ZIP			
HOME PHONE											
DATE OF BIRTH		SEX		MARITAL STATUS (M/S)		REFERRED BY					
DOCTOR		DOES YOUR INSURANCE COMPANY REQUIRE PRE-CERTIFICATION?									
ALLOW (Y/N)	STMT?		DUNNING?		INS. FORM?		PURGING?		TRANSFER?		
REMARKS											
REMARKS											
PATIENT S.S. NO.											
PATIENT'S EMPLOYER											
EMPLOYER ADDRESS											
CITY						STATE		ZIP			
EMPLOYER PHONE				EXT.							

GUARANTOR

RESP. PARTY LAST NAME		FIRST NAME & INITIAL				RELATIONSHIP	
ADDRESS							
CITY		STATE		ZIP		PHONE	
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.					
RESP. PARTY EMPLOYER							
EMPLOYER ADDRESS						EMPLOYER PHONE	

INSURANCE

MEDICARE OR INSURANCE # 1 NAME				INSURANCE #1 CODE	
INSURANCE #1 ADDRESS				INSURANCE #1 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
CERTIFICATE #		GROUP NO.		MEMBER NO.	
INSURANCE #2 NAME				INSURANCE #2 CODE	
INSURANCE #2 ADDRESS				INSURANCE #2 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
CERTIFICATE #		GROUP NO.		MEMBER NO.	
INSURANCE #3 NAME				INSURANCE #3 CODE	
INSURANCE #2 ADDRESS				INSURANCE #3 PHONE	
POLICYHOLDER LAST NAME		FIRST NAME		RELATIONSHIP	
CERTIFICATE #		GROUP NO.		MEMBER NO.	

SPOUSE'S NAME			
SPOUSE'S EMPLOYER		SPOUSE'S WORK PHONE	
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE	

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE DATE

LITHO USA 12/07 L02SF03034 9M