Date _____ Doctor _____ Acct# _____

PATIENT REGISTRATION FORM

Name: _____ Birth date: _____
First Initial Last

Marital Status: MARRIED SINGLE OTHER Sex: MALE FEMALE Soc Sec #: _____

Allergies: _____

Address: _____
Street Apt# City/State Zip

Home Phone: (_____) _____ Work Phone(_____) _____

Employer: _____
Name Address City/State Zip

Spouse's Name: _____ Employer: _____
First Initial Last

Work Phone: (_____) _____ Spouse's Soc Sec #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber Name: _____ Birth date: _____
First M.I. Last

ID# _____ Group #: _____

Relation to PT: _____ Co-pay: _____

Secondary Insurance: _____

Subscriber Name: _____ Birth date: _____
First M.I. Last

ID# _____ Group #: _____

Relation to PT: _____ Co-pay: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone #: _____

Authorization # if any: _____

EMERGENCY INFORMATION

Person to contact: _____ Phone #: _____

Relationship to PT: _____

The above information is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made in advance. I authorize the physicians and Overlake Internal Medicine Associates to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Signature: _____ **Date:** _____