

## PATIENT REGISTRATION

Name \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Sex  Male  Female  
Marital Status:  Single  Married  Separated  Divorced  Widowed  Minor  
Family Doctor \_\_\_\_\_ Referred by \_\_\_\_\_  
Patient's Employer/School \_\_\_\_\_  
Address \_\_\_\_\_  
In case of Emergency Notify \_\_\_\_\_ Telephone \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
Employer \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_

### SECONDARY INSURANCE

Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
Employer \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_

I certify that I, and/or my dependents, have insurance as stated above and the information provided is correct. I hereby authorize *Dr Honick* to apply for benefits on my behalf for services rendered by him or by his order. I request that all payments from my insurance company be made directly to *Dr. Honick*. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above named physician may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits for related services. A copy of this authorization may be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

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Signature

Date