DRS. PICKRON AND SMITH
NEW PATIENT REGISTRATION FORM

Today's Date: [Date]	**Primary Care Provider:**

PATIENT INFORMATION

Patient's last name: **First:**		**Middle:** **[Choose an item]**	**Marital status: [Choose an item]**
Primary Email Address:		**Secondary Email Address:**	**Work Email Address:**

Is this your legal name? ○ Yes ○ No	**If not, what is your legal name?**	**Former name:**	**Birth date:** **[Birthday]**	**Age:**	**Sex:** ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Occupation:	**Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option):
○ **[Doctor's name]**
◉ **[Choose an item]**

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(You must present proof of insurance and identification on day of treatment)

Person responsible for bill:	**Birth date:** **[Birthday]**	**Address (if different):** **[Address]**	**Home phone no.:** **[Phone]**
Is this person a patient here?	○ Yes ○ No	**Is this patient covered by insurance?**	○ Yes ○ No
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date: [Birthday]**	**Group no.:**	**Policy no.:**	**Co-pay: $**
Name of Insurance Co.:	**Insurance Co. Address:**	**Insurance Co. Provider Claim Phone #:**	**Waiting Period?** ◉ Yes ○ No **If so, when does coverage begin?** **[Date]**	**Deductible Amount:** **$**	**Annual Maximum Coverage:** **$**

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:** **[Group #]**	**Policy no.:** **[Policy #]**

Patient's relationship to subscriber: [Choose an item] | Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DRS. PICKRON AND SMITH or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**