

## Patient Registration & Insurance Verification Form

|                                 |                     |                                    |
|---------------------------------|---------------------|------------------------------------|
| <b>Practice Name:</b> _____     |                     |                                    |
| <b>Patient Name</b>             |                     |                                    |
| <b>Last:</b> _____              | <b>First:</b> _____ | <b>M:</b> _____                    |
| <b>Address:</b> _____           |                     |                                    |
| <b>City:</b> _____              | <b>State:</b> _____ | <b>Zip:</b> _____                  |
| <b>Home Phone:</b> _____        | <b>Cell:</b> _____  | <b>Email:</b> _____                |
| <b>DOB:</b> _____               | <b>SS#:</b> _____   | <b>Gender:</b> <b>M</b> / <b>F</b> |
| <b>Emergency Contact:</b> _____ | <b>Phone:</b> _____ | <b>Relationship:</b> _____         |

### Primary Insurance Information

|                                   |                              |                     |
|-----------------------------------|------------------------------|---------------------|
| <b>Carrier Name:</b> _____        | <b>Phone:</b> _____          |                     |
| <b>Claims Address:</b> _____      |                              |                     |
| <b>City:</b> _____                | <b>State:</b> _____          | <b>Zip:</b> _____   |
| <b>Member ID:</b> _____           | <b>Group #:</b> _____        |                     |
| <b>Insureds Name:</b> _____       | <b>DOB:</b> _____            |                     |
| <b>Employer:</b> _____            | <b>Employer Phone:</b> _____ |                     |
| <b>Secondary Insurance:</b> _____ | <b>ID#:</b> _____            | <b>Group:</b> _____ |



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**Technician Name:** \_\_\_\_\_ **Rep Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_