



PATIENT REGISTRATION

CFCG Physician _____ Date: _____

First Name: _____ Middle: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Phone/Contact: _____

Sex: F / M Marital Status: _____ DOB: _____ Social Security: _____

Referring Physician: _____

How did you hear about us? _____

Employer Name: _____

Address: _____

Phone #: _____

Insurance Information

Pre-certification telephone #: _____

Primary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____

Secondary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as an original. I authorize said assignee to release all information necessary to secure payment. I understand I am responsible for any deductible, co-payment, and or non-covered services. In the event my account is assigned to collection, I agree to pay all cost of collection including reasonable attorney fees.

PATIENT'S SIGNATURE _____

DATE _____