Patient Express Registration

Todays Date:

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

_____ _____ _____ ❑ Male ❑ Female
Last Name First Name Age

_____
Street Address City State ZIP

(_____)_____(_____)_____
Home Phone Cellular Email Address (Important)

_____(_____)_____
Emergency Contact Person Phone # (if minor) Parent/Guardian Name and Signature

_____(_____)_____
Occupation Employer Name Phone #

● My condition is related to: ❑ Work ❑ Auto Accident (State_____) ❑ Other_____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

_____
How did you hear about us?

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift.

_____

_____

_____
Primary or Referring Physician Name

_____
Street Address

_____
City State Zip

_____
Phone Fax

_____
Email Address

Do you have a followup appointment with this physician?_____

If yes, when? _____

3. Payment Info

(check only one box)

I am paying by **CASH, CHECK, CREDIT** and would like a . . .

❑ Payment plan. Fees may apply.

I have **INSURANCE** and would like to . . .

❑ Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form". Fees may apply. The following infor mation is required prior to 1st visit.

My coinsurance/copay is $_____

My deductible is $_____

Signature_____