Adult

Patient Registration

(Please print)

Date_____

Patient's Full Name_____DOB_____/_____/_____

Age_____ Gender: M F Non-Binary Cell Phone _____ Home Phone _____

Address_____City_____State _____Zip_____

Social Security#_____-_____-_____

Occupation:_____

Employed by:_____ Business Phone:_____

Marital Status: Single Married Divorced Separated Spouse's name:_____

Primary Care Physician's Name_____Phone:____ _____

Referred by:_____

In an emergency, please contact: _____Phone_____

E-Mail Address:_____

Insurance Company:_____

Certificate No._____**Subscriber**_____**DOB**: _____

Assignment of Duties

I hereby authorize Dr. Birns/Dr. Strocker to furnish to my insurance company all information that my insurance company may request concerning this illness or injury. I hereby assign to Dr. Birns/Dr. Strocker all payments to which I am entitled for medical and/or surgical expenses. I understand that I am financially responsible for all charges not covered by this assignment. A copy of this assignment is as valid as the original.

I hereby authorize Dr. Birns/Dr. Strocker to render whatever services are deemed necessary for the treatment.

Date:_____Signed: _____

(Signature of responsible party)

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