# PATIENT REGISTRATION

**PLEASE PRINT**

Today's Date: _____ Referring Physician _____

Mr. Mrs. Ms._____ Occupation/Employer: _____
(Last) (First) (M.I.)

Sex:___M ___F Birthday: _____ Age_____ Social Security: _____

Address: _____
(Street) (City) (State) (Zip)

Home # (_____)_____ Work # (_____)_____ Cell # (_____)_____

Has any immediate family member been a patient of Dr. Saunders _____Yes _____No

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***EMERGENCY CONTACT NUMBER***

Person we can contact in case of an emergency (someone NOT living with you)

Name _____ Phone # (_____)_____Relationship _____

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PARENT BRINGING CHILD IN FOR APPOINTMENT IS RESPONSIBLE FOR PAYMENT

Responsible Party: _____
(Last) (First) (M.I.) Relationship

Address: _____
(Street) (City) (State) (Zip)

Social Security: _____Home # (_____)_____Work # (_____)_____

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**MEDICAL INSURANCE INFORMATION: (Please present all insurance cards to receptionist)**

Insurance Company (Please check your insurance company):

_____ Medicare _____Medicaid _____ Blue Cross/Blue Shield

_____Other (name of other insurance company) _____

*** If you are NOT the subscriber of the insurance, please list the name and date of birth of the subscriber

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(Last) (First) (Date of Birth)

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IS YOUR CONDITION THE RESULT OF A WORK RELATED INJURY? _____ Yes _____No

**Our office does not evaluate worker's compensation patients**

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I authorize Dr. Saunders to administer medical care and/or surgical procedures. I authorize the release of any medical information concerning my treatment to Dr. Saunders and to my insurance company or companies (for billing). I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of my account. I will notify you of any changes in my health status or the above information.

PATIENT MUST SIGN: _____ DATE: _____

SIGNATURE OF PARENT OR GUARDIAN (if patient under 18): _____