INNOVATIVE
Family Wellness

Patient Registration

Patient Contact:

last name: _____ first name:_____ m.i.___
preferred to be called:_____
street:_____
city:_____ state:_____ zip:_____
home phone:_____ cell:_____
work phone:_____ email:_____

Patient Information:

age:_____ date of birth:____/____/_____ social security #:_____-_____-_____
sex: M:__ F:__ status: single___ married___

Emergency Contact:

name:_____ home/cell phone:_____
relationship:_____ work phone:_____

Spouse or Guardian:

last name: _____ first name:_____ m.i.___
employer name:_____
work phone:_____date of birth:____/____/_____

Patient Employment:

employer name:_____ occupation:_____
street:_____
city:_____ state:_____ zip:_____

How were you referred to our clinic?_____

I understand that health insurance policies are an arrangement between the insurance carrier and myself. I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If unpaid accounts necessitate collections, the cost of the collection agency will be added to my unpaid bill.

Patient's Signature:_____SS#_____Date: _____

Guardian's or spouse's signature authorizing care:_____Date:_____

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