

DATE _____

*******Please Print*****
Patient Registration Form**

Last Name: _____ First Name _____

Date of Birth: ____/____/____ S.S. # _____

Address: _____ APT# _____

City: _____ State _____ Zip _____

Home#: _____ Office#: _____

Cell#: _____ Email: _____

Sex: _____ Male _____ Female Occupation: _____

Primary Care Physician name and address: _____

Referred by: _____

*******PLEASE PRESENT YOUR CARDS TO STAFF*****
PRIMARY INSURANCE INFORMATION**

Name of Insurance Co.: _____

Policy#: _____ Group#: _____

Name of Insured: _____

Insured DOB: _____ S.S# _____

EMERGENCY CONTACT

Name: _____ Relationship _____

Home#: _____ Office# _____

Assignment and Release

I, the undersigned, have insurance coverage with _____

Name of Insurance Company

And assign directly to Dr. _____ all medical benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian _____ Date: _____

HIPAA PRIVACY PRACTICES NOTIFICATION

I, the undersigned, have been issued the HIPAA NOTICE OF PRIVACY PRACTICES. I fully understand that Romano and Associates is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services referred to me, and conducting health care operations.

Signature of Insured/ Guardian _____ Date: _____