REGISTRATION FORM

(Please print ~ Use black or blue ink)

Date_______________

Patient Information

Patient Name____ Male_____ Female _____ SSN__________________________

Mailing Address____ Date of Birth __________________ Married_____ Single______

City/State/Zip Code_____________________________________ Age _____________ Home Phone #______________________

Employer____________________________________ Occupation _________________ Business Phone #____________________

Primary Care Physician____

How did you hear about Dr Thornblade? ____

Insured Information (if not patient) or Person Responsible for Payment

Insured's Name____ Relationship to Patient__________________________________

Mailing Address____ Date of Birth ________________ SSN_____________________

City/State/Zip Code ____ Home Phone # ________________________

Employer ____ Business Phone # ______________________

Employer's Address____

Emergency Information

Person to Contact for Emergency ____ Daytime Phone # ____________________

Relationship to Patient____

Insurance Company Information

Primary Insurance Company ____ (Please Present Card for Photo Copying)

Mailing Address ____

City/State/Zip ____

Policy # ____________________________

Group #______________________________

Secondary Insurance Company ____

Secondary Insured's Name ____

Policy # __________________________ Group # _________________________

Authorization to Release Information and Assignment of Insurance Benefits

I authorize the release of any medical information necessary to process medical claims. I permit a copy of this authorization to be used in the place of the original. I hereby authorize that payment from my insurance company be made directly to Dr Thornblade and I understand that I am financially responsible for charges not covered by my insurance company.

____ Date___________________

(Signature of Patient, Policy Holder, or Parent)