PATIENT REGISTRATION

DATE________________________ DOCTOR________________________

PATIENT INFORMATION

NAME LAST	FIRST	M.I.	BIRTH DATE	HOME PHONE ( )
ADDRESS			MALE ☐ SINGLE ☐ DIVORCED ☐ FEMALE ☐ MARRIED ☐ WIDOWED ☐	
CITY	ZIP CODE		CELL PHONE	EMAIL
EMPLOYER			OCCUPATION	WORK PHONE ( )
ADDRESS			CITY	STATE / ZIP CODE
REFERRING DOCTOR	ADDRESS		CITY	STATE / ZIP CODE
IN CASE OF EMERGENCY CONTACT:	NAME			PHONE ( )
ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY			BIRTH DATE	PHONE ( )
ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT
EMPLOYER		OCCUPATION		WORK PHONE ( )
ADDRESS		CITY		STATE / ZIP CODE

INSURANCE INFORMATION

TYPE OF INSURANCE	I.D. NUMBER	GROUP NUMBER	NAME OF INSURED

CONSENT TO TREATMENT: I authorize and direct Brian S. Sayers, M.D. and/or Stephanie A. Booth, M.D. to perform upon me injections, draw blood and/or any other procedure/treatment they may determine advisable for my well being in their office. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

ASSIGNMENT AND RELEASE: I authorize release of any medical information necessary to process an insurance claim. I agree to be responsible for any copayments and/or services not covered by my insurance. I authorize payment of medical benefits to the physician or supplier of services.

NO SHOW POLICY: No shows and same day cancellations are subject to a $50 charge.

CONTACT INFORMATION provided above may be used to convey information regarding appointments, test results or billing issues.

SIGNATURE:________________________ Date: ____________