PATIENT REGISTRATION FORM

Exceptional Connections

Today's Date:_____ **Practice Name: Exceptional Connections Inc.**

_____ ____ _____ M__F__ _____
Patient Last Name First Name MI Date of Birth Sex SS#

_____ _____ ____ _____ _____
Street Address City ST Zip Home Telephone

_____ _____
Mailing Address (if different from street address) Alternate Telephone

Legal / Financially Responsible Party

_____ _____ M__F__ _____
Last Name First Name MI Date of Birth Sex SS#

_____ _____
Street Address City ST Zip Home Telephone

_____ _____ _____
Employer Name Address Work Telephone

_____
Email

Insurance Information

Primary Insurance	Secondary Insurance
Subscriber Name_____	Subscriber Name_____
DOB _____ SS#_____	DOB _____ SS# _____
Ins. Company_____	Ins. Company_____
Claim Address_____	Claim Address_____
_____	_____
ID / Contract#_____	ID / Contract#_____
Group #_____	Group#_____
PCP _____ (if listed)	PCP _____ (if listed)

If pre-certification is required, please list the telephone number specified on your insurance card.

_____ _____

Emergency Contact

Name_____ Telephone _____Relationship_____
Address_____
Do we have your authorization to contact this person concerning your medical services if the need arises? ____yes ____ no _____ initial (patient or responsible party)

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to _____ _____. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fee, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

x_____ _____ x_____
(Signature of Responsible Party) (Date) (Witness)