PATIENT REGISTRATION

DATE _____

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	DOB	AGE	SEX
ADDRESS	CITY		STATE	ZIP CODE	
PATIENT'S TELEPHONE	REFERRED BY (INCLUDE NAME & ADDRESS)				
PEDIATRICIAN'S NAME	ADDRESS		TELEPHONE		

BILL TO – PARENT OR GUARDIAN

FATHER OR GUARDIAN'S LAST NAME	FIRST NAME	MI	
ADDRESS IF DIFFERENT	CITY	STATE	ZIP CODE
TELEPHONE HOME	CELL	WORK	

MOTHER OR GUARDIAN'S LAST NAME	FIRST NAME	MI	
ADDRESS IF DIFFERENT	CITY	STATE	ZIP CODE
TELEPHONE HOME	CELL	WORK	

EMPLOYER INFORMATION

GUARANTOR NAME AND EMPLOYER	SPOUSE'S NAME & EMPLOYER
ADDRESS	ADDRESS
TELEPHONE / OCCUPATION	TELEPHONE / OCCUPATION

PRIMARY MEDICAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		
NAME OF INSURED	SOCIAL SECURITY NUMBER	DATE OF BIRTH
POLICY NUMBER	GROUP NUMBER	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Dr. Minou W. Colis to release any information acquired in the course of my examination or treatment to my family or insurance company. I authorize direct payment of medical benefits to Dr. Minou W. Colis for professional services rendered. I am aware that if there is inadequate insurance information on file for me the charges incurred will be my responsibility. I also understand that I am financially responsible for any outstanding balance.

SIGNED (PATIENT OR PARENT IF MINOR)	DATE