

## Registration Form

Patient Information				I.D. #	
Patient's name (last, first, middle)		Sex <input type="checkbox"/> female <input type="checkbox"/> male	Birthdate	Social Security #	
Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> widowed				E-mail	
Patient's home address		Apt. #	City	State	Zip Code
Patient's home phone	Patient's work phone	Employment status <input type="checkbox"/> full time <input type="checkbox"/> part time	Student status (if applicable) <input type="checkbox"/> full time <input type="checkbox"/> part time	Employer / School	
Occupation / Date Employed			Family physician referred by:		
Referred by: Name			Address		

How did you hear about us?

### Emergency/Other Contact Information

Name of emergency contact (last, first, middle)		Relation to patient	Home phone	Work phone
Emergency contact (not living with you): Name:		Relation to patient	Home phone	Work phone
<b>If patient is a student please provide permanent address information.</b>				Contact phone

### Person Responsible for bill (if other than patient)

Name (last, first, middle)		Social Security #	Home phone	Work phone
Responsible party's mailing address		Apt. #	City	State
Foreign Counter (if applicable)		Patient's relationship to person responsible for bill		
Employer (person responsible)		Occupation	Date employed	Work phone
Employer (spouse)		Occupation	Date employed	Work phone

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Patient's name (last, first, middle)			Social Security #		
Insurance Carrier # 1			Membership # /Policy #		Group #
Subscriber's name (last, first, middle)		Subscriber's birthdate		Patient's relationship to subscriber <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	
Effective date (if known)	Expiration date (if known)	For Champus patients only: Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine			Champus patients only: Status <input type="checkbox"/> active <input type="checkbox"/> retired <input type="checkbox"/> deceased
Insurance Carrier # 2			Membership # /Policy #		Group #
Subscriber's name (last, first, middle)		Subscriber's birthdate		Patient's relationship to subscriber <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	
Effective date (if known)	Expiration date (if known)	For Champus patients only: Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine			Champus patients only: Status <input type="checkbox"/> active <input type="checkbox"/> retired <input type="checkbox"/> deceased

### RELEASE OF INFORMATION

I hereby authorize Dr. Kuppusamy Ragupathi to release any and all medical records and other information in its possession necessary to confirm charges for service to all parties with legitimate interest in that information. Parties with a legitimate interest may include other physicians of hospitals, insurance companies, prepaid health care contractors, workers' compensation carriers, professional review organizations or others. This authorization will remain effective until revoked by me in writing.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

### AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby consent and authorize the administration of all treatments that may be considered advisable or necessary in the judgement of the physician.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

### ACKNOWLEDGMENT

I acknowledge that all information contained on this form is true and accurate. I further agree that I have read the above statements and understand everything in these statements. I intend and agree to be bound by all of the terms of this agreement.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_