

## PATIENT REGISTRATION FORM

<b>PATIENT INFORMATION</b>			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	First Name:	MI:	Last Name:
Address:			
City/State/Zip:			
Nickname:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Phone:	Work Phone:	Ext:	
Social Security Number:		Employer:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

<b>RESPONSIBLE PARTY</b>			
(If other than patient) <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	First Name:	MI:	Last Name:
Address:		City/State/Zip:	
Home Phone:	Work Phone:	Ext:	Drivers License No.:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:	Relationship to Patient:

(Please make sure insurance card available to front office personnel.)

<b>PRIMARY Insurance Name &amp; Address:</b>		
Policy Holder Last Name:	First Name:	Relationship to Patient:
Policy Holder Date of Birth:	Policy Holder Social Security Number:	
<b>SECONDARY Insurance Name &amp; Address:</b>		
Policy Holder Last Name:	First Name:	Relationship to Patient:
Policy Holder Date of Birth:	Policy Holder Social Security Number:	

### OTHER INFORMATION

Pharmacy Name & Phone Number	
Emergency Contact Name & Relationship:	Phone Number:

**FINANCIAL RESPONSIBILITY STATEMENT:**

If no insurance is to be filed by Dr. Khairy's office, full payment is due at time of service. Co-payments, co-insurance and non-covered services are due at time of service as well. A \$25.00 fee will be assessed for missed appointments without prior notification and for returned checks.

The undersigned acknowledges that in the event this account is turned over for collection, I will be responsible for the costs of collection which includes, but is not limited to, collection agency fees, reasonable attorney's fees, court costs, witness costs and prejudgment interest at 8% per annum. Each party further agrees that the Marion County Circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:**

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

I acknowledge receipt of a copy of Notice of Privacy Practices.

Date:	Patient Signature (Parent/Guardian):
-------	--------------------------------------