PATIENT REGISTRATION FORM

PATIENT NAME _____ _____
(LAST) (FIRST) (MI) SOCIAL SECURITY NUMBER

STREET OR BOX NO. _____ CITY _____ STATE_____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

❑ MARRIED ❑ DIVORCED ❑ SINGLE ❑ WIDOWED ❑ F ❑ M BIRTH DATE _____

PATIENT EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ PHONE _____

RELATIVE _____ PHONE _____ ADDRESS _____

❑ SPOUSE ❑ PARENT INFORMATION *(*If parent information, fill both name sections completely.)*

NAME _____ *NAME _____

ADDRESS _____ *ADDRESS _____

CITY _____ STATE ____ZIP _____ *CITY _____ STATE_____ ZIP _____

HM PH _____ WK PH _____ *HM PH _____ WK PH _____

SOC. SEC# _____ BIRTH DATE _____ *SOC SEC # _____ BIRTH DATE _____

EMPLOYER _____ *EMPLOYER _____

EMPL ADD_____ PH_____ *EMPL ADD_____ PH _____

PRIMARY INSURANCE **SECONDARY INSURANCE**

NAME OF INS. _____ NAME OF INS. _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE ____ ZIP _____ CITY _____ STATE ____ ZIP _____

PHONE _____ EFFECTIVE DATE _____ PHONE _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY HOLDER NAME _____

POLICY HOLDER BIRTHDATE _____ POLICY HOLDER BIRTHDATE _____

POLICY ID/GRP # _____ POLICY ID/GRP # _____

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: I hereby authorize my signature on all insurance and Medicare claim forms at the office of The Cobb Group for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33-1/3% will be added to my acount. I agee to pay that fee. I further agree to pay reasonable attorney fees and court costs. I understand and agee to the above terms.

SIGNATURE _____ DATE _____