PATIENT REGISTRATION FORM

Date Completed:_____

Patient Name:

Mailing Address:

City: **State:** **Zip:**

Physical Address if different from Mailing Address:

Home Phone: **Cell Phone:** **Work Phone:**

Birth Date: **Age:** **Social Security #:**

Employer: **Occupation:**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Widowed**

Smoker: ☐ **Yes** ☐ **No** **If Minor Mother's Name:**_____

Sex: ☐ **Male** ☐ **Female** **Child: Father's Name:**_____

Race: _____

For a minor child, to whom should we address correspondence (i.e. lab results, etc.)? _____

_____

Relative On Treatment Here: _____

How did you hear of our practice?

☐ **Friend** ☐ **Relative** ☐ **Telephone book** ☐ **Internet listing** ☐ **www.karimbranch.com** ☐ **Other**

RESPONSIBLE PARTY:

Name: **Social Security #:**

Mailing Address:

City: **State:** **Zip:**

Home Phone: **Work Phone:**

PRIMARY INSURANCE INFORMATION:

Company:

Address:

I.D. # **Group #:**

Insured Name: **Phone:**

Patient's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

SECONDARY INSURANCE INFORMATION:

Company:

Address:

I.D. # **Group #:**

Insured Name: **Phone:**

Patient's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Name of Referring Physician:

Address of Referring Physician:

Name of Family Physician:

Address of Family Physician:

Name, Address & Phone # of nearest relative (*not living with you*):

Primary Pharmacy & Phone #:

I authorize the release of any medical information necessary to process insurance claims filed on my behalf. I authorize payment of medical benefits to be made directly to the physician for services performed. I UNDERSTAND THAT I AM RESPONSIBLE TO KARIM & BRANCH, P.S.C., FOR ANY CHARGES INCURRED IN THE COURSE OF MY TREATMENT.

Patient/Guarantor or Guardian of Minor/Incapacitated Patient **Date Completed**