
Patient Information

Last Name: _____ First Name: _____

Address: _____

City/State/Zip Code: _____

Home Phone Number: _____ Age: _____

Cell Phone Number: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____ Employer Phone: _____

Marital Status: Married Single Divorced Widowed Other

Sex: Male Female

Responsible Party:

Name: _____ Social Security: _____

Employer: _____ Date of Birth: _____

Emergency Information:

Name: _____ Phone Number: _____

Address: _____

City/State/Zip Code: _____

Insurance Information:

Insurance Name: _____ Insurance Phone # : _____

Claims Address: _____

City/State/Zip Code: _____

Insured's Name: _____ Insured's SS# _____

Insured's Date of Birth: _____

Identification Number: _____ Plan/Group Number: _____

Referral Information:

How were you referred to our practice?

Friend/Relative Sign Dex Online Phone Book Employer Internet Health Plan Website Doctor Other

Other: _____

I authorize Regent Medical to release information regarding my treatment for insurance purposes or at my request. I understand that I am financially responsible for all charges. In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay the fees of the collection agency equal to the maximum of 50% of the outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action also be necessary to collect the account, I agree to pay attorney's fees and court costs incurred for collection. Thank You!

Signature: _____ Date: _____