Patient Registration

NYOG

Patient Name:_____ S.S.#_____Sex:_____

Home Address:_____ Date of Birth ___/___/___ Age_____

City/State/Zip:_____ E-mail address:_____

Home Phone:_____ Work Phone: _____Mobile Phone:_____

Occupation:_____ Employer:_____

Employer address:_____

Insurance Information

Primary:_____	Secondary:_____
Policy Holder:_____	Policy Holder:_____
Policy #:_____	Policy #:_____
Insured ID:_____	Insured ID:_____
Insured DOB:_____	Insured DOB:_____

I understand that I am financially responsible for all fees for services rendered to me including the balance remaining after the possible insurance benefits. I hereby authorize the direct payment of services rendered to me and authorize release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

Patient ☐ Guardian ☐