7656 W. Sahara Ste 110, Las Vegas, Nevada 89117
Phone: (702) 525-1105 Fax: (702) 666-8555

Patient Registration Form

Patient Information

Last Name:_____First Name:_____ MI_____
Mailing Address:_____City/State/Zip:_____
Physical Address:_____City/State/Zip:_____
Primary Phone:_____ Type: Home/Cell/Work **Message ok?** Y or N
Alternate Phone:_____ Type: Home/Cell/Work **Message ok?** Y or N
Email:_____ Used for **Doctor Contact** Y or N **Newsletter** Y or N
Social Security Number:_____Date of Birth:_____Male/Female
Marital Status: S M D W O
Employer:_____Occupation:_____

Referring Physician or Current Primary Physician:_____

Responsible Party Information (Parent information if patient is a Minor)

Name:_____
Address:_____City/State/Zip:_____
Primary Phone:_____Alternate Phone:_____

Insurance Information

*Primary Insurance Company Name:_____
*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other
*Name of Subscriber:_____*Date of Birth:_____
*Social Security Number:_____Male/Female
*Insurance ID#:_____Group#:_____Effective Date:_____

*Secondary Insurance Company Name:_____
*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other
*Name of Insured:_____*Date of Birth:_____
*Social Security Number:_____Male/Female
*Insurance ID#:_____Group#:_____Effective Date:_____

Emergency Contact Information

Name:_____Relationship:_____
Primary Phone:_____Alternate Phone:_____

I certify that the above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Responsible Party Signature: _____

Responsible Party's Relationship to Patient: _____

Today's Date: _____