Patient Registration Form **Account Number**__________

New Patient Yes No (circle one) How did you find out about our practice?__________________

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Patient Last Name ____________________First ____________________Middle__________

Patient Address ____

Patient Address____________________City________________State_____Zip __________

Home Phone______________Cell Phone________________ Sex ______Marital Status ________

Date of Birth__________Email Address______________________________________

Social Security Number________________ Employer Name____________________________

Employer Address________________________________ Work Phone______________

Guarantor Last Name ____________________ First ______________ Middle__________

Guarantor's Address ____

City ____________________State ______Zip________Home Phone____________________

Relationship to Patient ________Employer________________ Work Phone ______________

Date of Birth ________Emergency Contact______________Phone Number________________

Primary Insurance ____________________**Policyholders Name** ____________________

Certificate Number __________________Group Number __________ Coverage: Self Spouse Family
CIRCLE ONE PLEASE

Secondary Insurance ____________________**Policyholders Name** ____________________

Certificate Number __________________Group Number __________ Coverage: Self Spouse Family
CIRCLE ONE PLEASE

I authorize Oyster Point Family Practice to release any medical information necessary to submit my insurance claims or to notify others as required. I request that my insurance companies pay benefits directly to Oyster Point Family Practice. I understand that Oyster Point Family Practice will refund me any overpayment due to me. I understand that I am financially responsible for all services received. I understand that I am responsible to pay all expenses incurred in collecting unpaid fees, including 33 1/3% collection fees on unpaid balances. It is my ultimate responsibility to collect benefits from my insurance companies. I take full responsibility for assuring that my insurance companies are properly notified in the event second opinions, pre-certifications, or pre-admission authorizations are required prior to services rendered.

Signed______________________________________ Date ____________________