

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____

Address: _____

Sex: Female Male Social Security Number: _____ - _____ - _____ Marital Status: _____

Home No.: _____ Cell No.: _____ E-Mail: _____

Employer: _____ Work No.: _____

Emergency Contact Name: _____ Phone Number: _____

Please Circle Race: African American / American Indian / Asian / Pacific Islander / White / Other: _____

Ethnicity: _____ Language: _____

*** If patient is a minor:** Name of person financially responsible: _____

Relationship to Patient: _____

How Did You Hear About Dr. Sullivan?: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

Referred By: _____ Phone Number: _____

Address: _____

Insurance Carrier (PRIMARY): _____

Group #: _____ Member/ID #: _____ Employer: _____

Date Effective: _____

Policy Holder's Name: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____ Sex: Female Male Relationship: _____

Secondary Insurance Carrier: _____

Group #: _____ Member/ID #: _____ Employer: _____

Specialist Co-pay amount: _____ Date Effective: _____

Policy Holder's Name: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____ Sex: Female Male Relationship: _____

_____ * I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-pays, or coinsurances. *I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. *I authorize my provider's office to contact me by telephone to remind me of my appointments.

Patient's Signature

Date