

# REGISTRATION FORM

PATIENT INFORMATION			
Patient Last Name:		First:	Middle:
DOB:	Age:	Sex: Male Female	
Street Address:		Social Security #:	
City:	State:	Zip Code:	Home Phone #:
Occupation:	Employer:		Cell Phone #:
Who may we thank for referring you?			
PCP:		PCP Phone #:	
Pharmacy Name:		Address:	
Pharmacy Phone #:			

## INSURANCE INFORMATION

Person Responsible for bill:		DOB:
Address (If different):		Contact #:
<b>Primary Insurance:</b>		
Subscriber's Name :	Subscriber's SS#:	DOB:
Group #:	Policy #:	
Patients relationship to subscriber:		
<b>Secondary Insurance:</b>		
Subscriber's Name :	Subscriber's SS#:	DOB:
Group #:	Policy #:	
Patients relationship to subscriber:		

## IN CASE OF EMERGENCY

Name:	Relationship to Patient:
Contact #:	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The CIIT Center or my insurance company to release any information required to process my claims.	

**Patient/ Guardian Signature**

**Date**