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 #:
Email:			
PCP:		PCP Phone #:	
Pharmacy Name:	Address:		
Pharmacy Phone #:			

INSURANCE INFORMATION

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