PATIENT REGISTRATION

Name:_____ Age: _____ Today's date: _____

Address: _____

_____ DOB: _____

BEST CONTACT PHONE: Is detailed message ok? Yes No	Please circle all that apply Personal cell Home Work other.
Alternate phone number Is detailed message ok? Yes No	Personal cell Home Work other

Email: _____(Used for appointment reminders. Only provide if you consent to email communication, and if you have read and agree to the paragraph regarding "Email communication" in the "Office Policy" form.)

Person who referred you: _____

Emergency Contact: _____ relationship:_____Contact phone: _____

Primary Care Doctor: _____Phone number_____

Do you want your primary care doctor to receive a letter from Dr. Alexander? Please circle: yes no unsure

WHO IS RESPONSIBLE FOR PAYMENT? (please initial) **_____**I will be responsible ____Another person

PERSON RESPONSIBLE FOR PAYING THE BILL IF DIFFERENT FROM PATIENT:

Name: _____ Relationship: _____

Address: _____

Phone numbers Day:_____Evening_____other:_____

By listing someone other than myself as the person responsible for payments, I recognize that that person will be aware that I am seeing Dr. Alexander, dates of visits, and general purpose of the visits. I consent to Dr. Alexander or her representative contacting the person responsible for the bill, in order to verify that they are assuming financial responsibility, and to discuss matters related to payment. (Initial here)_____

INSURANCE INFORMATION

Insurance company: _____ Subscriber: _____

Group: _____ Policy #: _____ Subscriber DOB: _____

Any secondary insurance? Please give details:_____

RELEASE OF INFORMATION FOR INSURANCE PURPOSES, AND ASSIGNMENT OF BENEFITS:

Unless I pay in full at the time of service, I authorize the release of information to any insurance carrier or its intermediaries regarding the services provided. Unless payment has already made in full, I consent to benefits being assigned to Dr. Alexander for services rendered.

_____ _____

Signature date