

Registration Record

Today's Date _____

Patient's Name _____ M F
FIRST MIDDLE LAST SEX

Patient's Address _____
NUMBER AND STREET CITY AND STATE ZIP

Patient's Phone (_____) _____ Cell Phone (_____) _____ Birthdate _____

Social Security Number _____ Email _____

Employer _____ Employer's Phone (_____) _____

Employer's Address _____
NUMBER AND STREET CITY AND STATE ZIP

Responsible Party _____
NAME ADDRESS CITY AND STATE ZIP

Responsible Party's Phone (_____) _____ Responsible Party's Employer Phone (_____) _____

Name of Insurance Company _____

Name of the Insured Person _____

S.S.# of the Insured Person _____ Insured Person's Date of Birth _____

Name of Second Insurance Company _____

Name of Insured Person (for 2nd Insurance) _____

S.S.# of the Insured (for 2nd Ins) _____ Insured Person's Date of Birth (2nd Ins) _____

Person to Contact in Case of Emergency _____

Emergency Contact's Phone (_____) _____ Relationship _____

Emergency Contact's Address _____

Having received and read the Notice of Privacy Practices provided by Dr. Degan, I hereby give my consent for Dr. Degan to use and disclose protected health information about me to carry out treatment, payment, and health care operations. I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Dr. Degan reserves the right to revise the Notice of Privacy Practices at any time.

Signature of Patient or Legal Guardian

Date