PATIENT REGISTRATION

Patient Name:			
Address:			
Home Phone:		Cell Phone:	
Email:			
DOB:	SSN#	Circle One: MALE FEMALE	Marital Status:
Employer Name:			
Address:			
Work Phone:			
How did you hear about us:			

INSURANCE INFORMATION

Policy Holder Name:			
Address:			
Home Phone:		Relationship to Patient:	
DOB:	SSN#	Circle One: MALE FEMALE	Policy Holder Employer:
Insurance Company Name:	Group #	ID #	

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured/patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage.

I hereby give the physicians of UHN permission to treat me or my dependent(s), and I authorize UHN to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed "non-covered" by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits to the physicians of UHN for services described herein. Regardless of my insurance benefits, if

Signature of Patient or Guardian:	Date: