New Patient Registration Form

Patient Information:

Last Name: _____ **First Name:** _____ **DOB:** _____ **M F**

Last Name: _____ **First Name:** _____ **DOB:** _____ **M F**

Last Name: _____ **First Name:** _____ **DOB:** _____ **M F**

Parent/Responsible Party Information:

Father's Last Name: _____ **First Name:** _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Cell Phone: _____

Mother's Last Name: _____ **First Name:** _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Cell Phone: _____

Primary Insurance Information:

Primary Insurance Plan Name: _____

ID Number: _____ Group Number: _____

Name of Parent Child Insured Under: _____

Employer Name(If Applicable): _____

1) CONSENT TO TREATMENT. The undersigned consents to any medical or surgical treatment rendered to the above named patient that may be considered advisable and necessary in the judgment of the physician
2) RELEASE OF INFORMATION. The undersigned agrees that Dr. Akey's Office may release medical records or other information necessary to secure payment from insurance companies, health care service plans or Worker's Comp carriers.
3) PAYMENT TERMS AND ASSIGNMENT OF BENEFITS. The undersigned authorizes payment to the above provider of benefits due me under any terms of any insurance policy or policies that may cover provider's professional services rendered to the above names patient. I understand that I am financially responsible to the provider for services not paid by said insurance policies. This responsibility includes services rendered but not authorized by the patient's health insurance plan or when the provider is not a contracted provider with the health insurance plan.

Parent Signature/Guardian: _____ **Date:** _____

Relationship to Patient: _____ **Email Address:** _____

Referred By: _____

Pharmacy: _____ **Pharmacy #:** _____