

Registration Form

Patient Information

Name: _____ Date: _____
 Address: _____ Home Phone: () _____
 City: _____ State: _____ Cell Phone: () _____
 Sex: M F Age: _____ Birthdate: _____ SSN: _____
 Patient's School: _____
 Mother's Name: _____ Father's Name: _____
 Parent(s) Marital Status: Married Divorced Separated Custodial Parent: _____
 Who Shall we thank for referring you? _____
 In case of emergency who should be notified? _____ Phone: _____

Primary Insurance

Person Responsible for Account: _____
 Relationship to Patient: _____
 Address (if different from patient): _____
 City: _____
 Person Responsible Employed by: _____
 Business Address: _____
 Insurance Company: _____
 Insurance Address: _____
 Insurance Phone: _____ Subscriber #: _____ Group #: _____
 Names of other dependents covered under this plan: _____

Additional Insurance

Is the Patient covered by additional Insurance? Yes No Subscriber Name: _____
 Relation to Patient: _____ Birthdate: _____ SSN: _____
 Address (if different from patient): _____ Phone: _____
 City: _____ State: _____ Zip: _____
 Subscriber Employed by: _____ Business Ph: _____
 Insurance Company: _____
 Insurance Address: _____
 Insurance Phone: _____ Subscriber #: _____ Group #: _____
 Names of other dependents covered under this plan: _____

Assignment and Release: I hereby assign all medical benefits to which I am entitled to T.U.N. CADD in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, the collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of T.U.N. CADD as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Signature of Patient, Parent, Guardian or Personal Representative

Date