Patient Registration Information

Legal Name _____

Address _____

City _____ **State** _____ **Zip code** _____

Home Phone _____ **Cell Phone** _____ **Text Msg? Y N**

Email address _____

Sex ☐ Male ☐ Female **Age** _____ **Birthdate** _____

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Parents (if minor) _____ **Spouse/Partner name** _____

Children (names & ages) _____

Occupation _____ **Employed by** _____

Activities at Work _____

How did you hear about Dr. Cayer? ☐ Returning Patient ☐ Internet/Website ☐ Lecture Series
☐ Yellow Pages ☐ Newspaper ad ☐ Restaurant/Church flyer ☐ Friend/ Family ☐ Other
If Friend/Family or Other, please comment _____

Primary Insurance

Copy of photo ID and insurance card will be requested at initial visit

Policy Subscriber _____ **Birthdate** _____

Relation to Patient _____ **Employer** _____

Insurance Company _____ **Policy Renewal date** _____

Additional Insurance

Is the patient covered by additional insurance? ☐ yes ☐ no

Subscriber name _____ **Ins. Company** _____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Cayer all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of my benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not covered by the insurance.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date