



### 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