

Carolina Arthritis Center

Patient Registration Form

Last Name		First Name	Middle Initial	SSN
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Referring Physician		Home Phone ()
Mailing Address		City	State	Zip
Employer Name			Work Phone ()	
Employer Street Address		City	State	Zip
Contact Phone Number for Appointments and Test Results Between 8:30am and 5:00pm ()			Cell Phone ()	
Emergency Contact				
Name			Phone ()	

Insurance Information

Primary	Secondary
Insurance Company Name	Insurance Company Name
Policy Holders Name	Policy Holders Name
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder Social Security Number	Policy Holder Social Security Number
Policy Number	Policy Number
Group Number	Group Number

I hereby authorize my insurance benefits to be paid directly to Carolina Arthritis Center, PA realizing I am responsible for payment of noncovered services.

Patient's Signature _____ Date _____

I hereby authorize the release of pertinent medical information to insurance carriers and my referring physicians.

Patient's Signature _____ Date _____