CORNERSTONE
AUTISM CENTER

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: M / F

Full Address: _____

Home Phone: (_____) _____-_____

FINANCIALLY RESPONSIBLE PERSON

Name: _____ Date of Birth: _____/_____/_____

Full Address: _____

Home Number: (_____) _____-_____ Cell Number: (_____) _____-_____

Employer Name: _____ Employer Phone Number: (_____) _____-_____

Employer Address: _____

FIRST INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

I authorize the release of any medical information, by Cornerstone Autism Center or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, co-pay or co-insurance balances, or amounts not covered by my insurance policy.

Signature: _____ Date: _____