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: ____________________