DR. PAULA D. MOORE
DYSAUTONOMIA-MVP CENTER

The data on this confidential form is essential to render the best professional care. Please fill out the answers carefully. If you have any questions, please ask.

PATIENT REGISTRATION FORM

Patient Information

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Street Address	City	State	Zip Code

Home Phone #:	Work Phone #:	Cell Phone #:	Email Address:	Race
( ) -	( ) -	( ) -		

☐ Employed ☐ Retired ☐ Disabled ☐ Student	If employed, who is your employer?	Employer Phone Number: ( ) -

Date of Birth / /	Age	Social Security #:	Driver's License Number:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Gender ☐ M ☐ F

Insurance Information

Occupation	Insured's Employers

Insured's Employer's Address

Please indicate primary insurance:

Insured's Name:	Insured's S.S. #:	Insured's ID	Co-Payment Amount $

Insurance Type:	Subscriber #:	Group #:

Patient's Relationship to Insured	☐ Self	☐ Spouse	☐ Child	☐ Other _____	Insured's Date of Birth: / /

Please indicate secondary insurance (if applicable):

Insured's Name:	Insured's S.S. #:	Insured's ID	Co-Payment Amount $

Insurance Type:	Subscriber #:	Group #:

Patient's Relationship to Insured	☐ Self	☐ Spouse	☐ Child	☐ Other _____	Insured's Date of Birth: / /

Does your plan require a referral? ☐ Yes ☐ No	If Yes, was a referral obtained? ☐ Yes ☐ No	Referral Number:

Who is financially responsible for this account?	☐ Self	☐ Spouse	☐ Parent	☐ Other

Primary Physician Information

Medical Doctor's Name	Medical Doctor's Phone Number ( ) -

Medical Doctor's Street Address	City	State	Zip Code

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*