REED THERAPEUTIC SERVICES LLC
REGISTRATION FORM

Today's Date:

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Email Address: Cell Phone:					Birth date:	Age: Sex: ☐ M ☐ F
Street address:			Social Security no.:		Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Referred to Alex by (Please check one box):			☐ Dr.			☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Website / Internet	☐ Other		
Other family members seen here:						

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill:	Birth date:	Address (if different):			Home phone no.: ( )
Is this person a patient here? ☐ Yes ☐ No					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance					
Insurance Company Address:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

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

All accounts are the responsibility of the individual patient or guardian and payments are to be made at the time of the appointment. This office will assist you in filing insurance, but takes no responsibility for denial of or delay in payment. A CHARGE WILL BE MADE FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS. I authorize the provider to release to my insurance company(ies) and their bona fide agent(s) such information as may be required to adjudicate my claim, I authorize direct payment to medical benefits to the provider and I hereby assign and set over to such provider all of such benefits. I understand that I am financially responsible to the provider for charges not covered by this authorization.

Patient/Guardian signature *Date*