

MASTER REGISTRATION INFORMATION

PLEASE PRINT				DATE:			
PATIENT INFORMATION (PERSON BEING SEEN)							
LAST NAME			FIRST			M.I.	
STREET ADDRESS				APT. NO.		SOCIAL SECURITY NO.	
CITY		STATE		ZIP		BIRTH DATE / /	
				<input type="checkbox"/> MALE		<input type="checkbox"/> FEMALE	
EMAIL ADDRESS			CELL PHONE NO.:			HOME PHONE NO. EXT	
EMPLOYER			OCCUPATION			WORK PHONE NO.: EXT	

PRIMARY INSURANCE INFORMATION							
INSURANCE CO/PLAN (PRIMARY)			EMPLOYER GROUP#		PHONE # EXT		POLICY NO.
INSURANCE CLAIM ADDRESS			PATIENT RELATIONSHIP TO POLICY HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER			INSURANCE EFFECTIVE DATES:	
LAST NAME POLICYHOLDER			FIRST			M.I.	
STREET ADDRESS			APT. NO.		CITY		STATE
						ZIP	
SOCIAL SECURITY NO.			HOME PHONE NO.		DATE OF BIRTH		WORK PHONE NO. EXT <input type="checkbox"/>
							MALE <input type="checkbox"/>
							FEMALE <input type="checkbox"/>

SECONDARY INSURANCE INFORMATION							
INSURANCE CO/PLAN (PRIMARY)			EMPLOYER GROUP#		PHONE # EXT		POLICY NO.
INSURANCE CLAIM ADDRESS			PATIENT RELATIONSHIP TO POLICY HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER			INSURANCE EFFECTIVE DATES:	
LAST NAME POLICYHOLDER			FIRST			M.I.	
STREET ADDRESS			APT. NO.		CITY		STATE
						ZIP	
SOCIAL SECURITY NO.			HOME PHONE NO.		DATE OF BIRTH		WORK PHONE NO. EXT <input type="checkbox"/>
							MALE <input type="checkbox"/>
							FEMALE <input type="checkbox"/>

PATIENTS OR AUTHORIZED PERSONS SIGNATURE _____ I AUTHORIZE
 PAYMENT OF MEDICAL BENEFITS TO _____
 I AUTHORIZE ELAYNE LANSFORD, Ph.D. TO RELEASE INFORMATION NECESSARY _____ ELAYNE LANSFORD,
 Ph.D. FOR SERVICES RECEIVED
 TO PRECESS INSURANCE CLAIMS

SIGNED _____ DATE: _____ SIGNED _____
 (INSURED OR AUTHORIZED PERSON)

WHO IS RESPONSIBLE FOR PAYMENT? POLICY HOLDER OTHER; IF OTHER. INDICATE PERSON RESPONSIBLE							
LAST NAME		FIRST		HOME PHONE NO.		WORK PHONE NO. EXT	
STREET ADDRESS			APT. NO.		CITY		STATE
						ZIP	

IN CASE OF EMERGENCY, PLEASE CONTACT

LAST NAME	FIRST	RELATIONSHIP TO PT.	BEST PHONE NO.	WORK PHONE NO.
STREET ADDRESS	APT. NO.	CITY	STATE	ZIP