talk&play ASSOCIATES

New Patient Registration Form

Date: _____ Referring Physician: _____

PATIENT INFORMATION			
Patient's Last Name:	First:	Middle Initial:	Parent or Guardian Name:
Address:		City:	Zip Code:
Home Phone:	Cell Phone:	Birthdate:	Email Address:
Referred to clinic by (please check one box): ☐ Physician ☐ Insurance ☐ Friend / Family ☐ Internet ☐ Other			

INSURANCE INFORMATION			
Is this patient covered by insurance? ☐ Yes ☐ No	Please indicate primary insurance: ☐ Tricare ☐ Medicaid ☐ United Healthcare ☐ Anthem ☐ Other		
Subscriber Name	Birthdate:	Address (if different):	
Employer:		City:	Zip Code:
Subscriber ID No.:	Subscriber Group No.:	Patient's relationship to Subscriber? ☐ Self ☐ Child ☐ Spouse	

SECONDARY INSURANCE INFORMATION		
Is this patient covered by a secondary insurance? ☐ Yes ☐ No	Insurance Carrier Name:	Subscriber ID No.:

CONSENT & FINANCIAL AGREEMENT

I understand that co-payment is due at the time of service. I understand that I am responsible for all costs **NOT** covered by my insurance. I also understand that I am responsible for any and all charges denied by my insurance company that are deemed not medically necessary. I authorize my insurance benefits to be paid directly to Talk & Play Associates. I also authorize Talk & Play Associates to release any information required to process my claims directly to my insurance company.

_____ _____

Parent/Guardian Signature **Date**