Teresa Hoffman, M.D. & Associates, LLC

PATIENT REGISTRATION - PLEASE PRINT CLEARLY

Patient Name First Middle Last		Name You Wish to be Called	Age & Date of Birth
Home Address Apt. No.		City, State & Zip Code	
Cell Phone	Home Phone	Email Address	
Social Security No.	Preferred Language	Marital Status (circle one) Single Married Separated Divorced Widowed Partnered	
Race (circle one) American Indian/Alaska Native Native Hawaiian/other Pacific Islander Asian White Black/African American		Ethnicity (circle one) Hispanic/Latino Non-Hispanic/Non-Latino	
Employer (or previous employer, if retired)	Work Address		Work Phone – ext
Name of Insured Person and Relationship to You			Social Security No of Insured Person
Address of Insured Person	Date of Birth of Insured Person		Phone No. of Insured Person
Name of Spouse (or Parent)	Home Phone		Cellular Phone
Address of Spouse (or Parent)	Work Phone		
Emergency Contact	Relationship	Home Phone **or** Cellular Phone	Work Phone – ext
Emergency Contact Address			
Primary Care MD	Address		Office Phone

Patient Authorization

I certify that the information I have reported with regard to my health insurance coverage is correct and I have read and understand the Insurance and Billing information and patient policies. I authorize the release of any necessary information, including medical information for this and any related claim, to the above named Insurance Company (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or me at any time.

Date	Signature of Patient or Guardian

Acknowledgment of Receipt of HIPAA Policy

I acknowledge that I have received information regarding the HIPAA Policy.

Date	Signature of Patient or Guardian