EXTENDED LIFE WELLNESS CENTER
New Patient Registration Form
954.921-9555 (P) - 954.921.9556 (F)

Patient information:

Today's Date:_____ Account #: _____

Name: _____ DOB: _____

Mailing Address:_____ Age: _____

City, State, Zip: _____ SSN: _____

Phone: _____ Marital Status: Married ( ) Single ( ) Other ( )

In case of Emergency, Notify: _____ Sex: Male ( ) Female ( )

Phone: _____ Referred by: _____

Relationship to patient: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ ID Number: _____

Mailing Address: _____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip: _____

Name/Policy Holder: _____ Name/Policy Holder: _____

SSN: _____ SSN: _____

DOB: _____ DOB: _____

Employment Information

Employer: _____ Telephone: _____

Mailing Address: _____ City, State, Zip: _____

Responsible Party Information

Name: _____ *As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility*

Mailing Address: _____

City, State, Zip: _____ X _____

Responsible Party Signature

DOB: _____

Phone: _____

SSN: _____

Payment of Benefits
I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _____ Date: _____

Medical Release Authorization
I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ Date: _____

Cancellation of Scheduled Appointments
I understand that if I have a serious emergency and I am unable to come to my appointment, I will contact the office as soon as possible. In other cases, if I fail to cancel my appointment 24 business hours in advance, I will be charged $60.00 for the missed appointment.

Signature: _____ Date: _____