

## BRYAN E. VIGNERY, LCPC, LPC REGISTRATION FORM

Today's Date:

PATIENT INFORMATION (PLEASE PRINT)							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Email Address:				Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Cell Phone:							
Street address:			Social Security no.:		Home phone no.: (    )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: (    )		
Referred to Bryan by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Website / Internet	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.: (    )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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.: (    )
<p>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.</p>			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	