

**DORAN CLINIC  
PATIENT REGISTRATION FORM**

**Acct. #** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Personal Information**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS# \_\_\_\_\_ Marital Status \_\_\_\_\_ Employment: // Full-time // Part-time // Self // Student  
U.S. Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ \*\*\* Referring Physician: \_\_\_\_\_  
Home Country Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
\*\*\*Have you ever been seen here before today under another name? \_\_\_\_ If so, please list name: \_\_\_\_\_

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**Emergency Contact**

Friend/Relative(not living with you) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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**INSURANCE COVERAGE (Primary) (1)**

Name of Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policyholder's Name: \_\_\_\_\_ Birth date \_\_\_\_\_ Policy # \_\_\_\_\_  
Policyholder's Employer: \_\_\_\_\_ Group # \_\_\_\_\_  
**Patient Relationship to Policyholder:** \_\_\_\_\_

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**INSURANCE COVERAGE (Secondary) (2)**

Name of Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
**Policyholder's Name:** \_\_\_\_\_ Birthdate \_\_\_\_\_ Policy # \_\_\_\_\_  
Policyholder's Employer: \_\_\_\_\_ Group # \_\_\_\_\_  
**Patient Relationship to Policyholder:** \_\_\_\_\_

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**Release and Assignment of Benefits**

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment for medical services go directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me (to include services designated by my insurance company as non-medically necessary, investigational, noncovered, and/or experimental).
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I understand I am financially responsible to Doran Clinic for charges not covered by my insurance (to include services designated by my insurance company as non-medically necessary, investigational, noncovered, and/or experimental).

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian(if under 18) \_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I specifically authorize the release of medical information **necessary to process my insurance claim** relating to: (check appropriate box)  
// Mental Health(including depression, mood swings, etc)      // Substance Abuse (including alcohol/drug abuse)  
// HIV-related information  
\_\_\_\_\_  
Date \_\_\_\_\_  
Parent or Guardian(if under 18) \_\_\_\_\_