Wyoming Recovery

Patient Registration Form and Authorization of Benefits

Last Name:	**First Name:**	**MI:**	
Birthdate:	**Age:**	**Sex: M ◯ F ◯**	**Social Security Number:**
Mailing Address:	**City:**	**State:**	**Zip:**
Physical Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Email:**	
Employer:	**Work Phone:**		
Spouse's Name:	**Work Phone:**		

Physician: _____ **Phone:** _____

Dentist: _____ **Phone:** _____

Whom may we contact in the case of an emergency: _____ **Phone:** _____

Nearest Relative not living with you: _____ **Phone:** _____

How did you hear about Wyoming Recovery?

Referral Name: _____ **Phone:** _____

☐ **Internet search** ☐ **Radio** ☐ **Flyer** ☐ **Other**

Insurance Company Name:	**Phone:**
Subscriber Name:	**Subscriber Employer:**
Subscriber Social Security Number:	**Subscriber Birthdate:**
Group Number:	**Individual Number:**
Secondary Insurance Company Name:	**Phone:**
Group Number:	**Individual Number:**

Race ☐ 1. White ☐ 2. Black ☐ 3. Native American ☐ 4. Hispanic ☐ 5. Asian ☐ 6. Other

Marital Status ☐ 1. Never Married ☐ 2. Married ☐ 3. Widowed ☐ 4. Divorced ☐ 5. Separated ☐ 6. Living married ☐ 7. Other

Employment Status ☐ 1. Unemployed ☐ 2. Part-Time ☐ 3. Full-time ☐ 4. Retired ☐ 5. Disabled Unemployed ☐ 6. Student ☐ 7. Other

If a person other than the patient listed above is responsible for paying the bill, please complete the following Guarantor information:

Guarantor's Name:	**Mailing Address:**	
City:	**State:**	**Zip Code:**
Phone:	**Relationship to patient:**	

_____ *Initials* *I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. If the account is not paid as agreed I understand that I am financially responsible for all reasonable collection costs.* ***I understand that patients can be fired for repeated non-compliance with doctor's instruction or office policies, repeatedly missing scheduled appointments, for not paying bills, for altering a prescription and other reasons at the doctor's discretion on a case by case basis.*** *I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. I understand the Wyoming Recovery may share my health information for treatment, billing and healthcare operations. I have been given a copy of Wyoming Recovery's notice of privacy practices that describes how my health information is used and shared. I understand that Wyoming Recovery has the right to change this notice at any time. I may obtain a copy by contacting Wyoming Recovery. I also understand that Wyoming Recovery will maintain my medical record for 7 years after termination of treatment, except for minors whose records will be maintained until the minor attains the age of seven years beyond the age of majority.*

_____ _____

Signature: **Date:**

Signature if Minor: Date: