City Infusions
Your Relief Starts Here

PATIENT REGISTRATION & CONSENT FORM

Patient Information

Patient Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Social Security Number: _____

Home Phone: _____ Email Address: _____

Address: _____

Insurance Information

Primary Insurance Name and ID number: _____

Secondary Insurance Name and ID number: _____

Is the patient the subscriber/policy holder? ☐ Yes ☐ No

If not, provide policy holder's Name: _____ DOB: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Consent & Authorization

I consent to treatment and authorize the release of medical information as required for care and payment.

I acknowledge financial responsibility for charges not covered by insurance.

Signature

Signature: _____ Date: _____