Patient Registration Form
Clarity Laboratories, Inc.

Patient's First Name	Last Name	M.I.
Address		
City	State	Zip
Home Phone	Cell	Work
Birth Date / /	Age	Social Security # - -	Sex M F
Employer's Name	Practitioner's Name	
Current Medications		

If the patient is a minor, please fill in the parent's names and phone numbers below.

Parent Name	Parent Name
Parent Phone	Parent Phone

Primary Insurance Company	**Secondary Insurance Company**
Ins. Co. Name _____	Ins. Co. Name _____
Ins. Co. Address _____	Ins. Co. Address _____
_____	_____
_____	_____
Ins. Phone # _____	Ins. Phone # _____
Group # _____	Group # _____
ID# _____	ID# _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's DOB	Subscriber's DOB

Who referred you to Clarity Laboratories? ☐ Doctor ☐ Therapist ☐ Other	**I authorize Clarity Laboratories, Inc. to send results of my assessment to my referring doctor or therapist.**
Name	_____ Signature Date

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Clarity Laboratories, Inc. and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance carrier.

Signature Date

FAX: (888) 908-6361
E-FAX: fax@claritylaboratories.com
PHONE: (802) 658-6321

CLARITY LABORATORIES