PATIENT REGISTRATION

Patient Information:

First Name: _____ Last: _____ MI: _____ Preferred Name: _____

Address: _____ City: _____ St: _____ Zip:_____

Cell Phone: _____ Work Phone: _____ Ext:_____ Hm. Phone: _____

Gender: ☐ Female ☐ Male Marital status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Birth Date: _____ Age: _____ SS#: _____ Drivers Lic: _____

Email: _____ Today's Date: _____

Who should we contact in case of emergency: _____ Relationship: _____Phone: _____
Is there anyone other than yourself or parent if patient is under 18yrs old that you would like us to speak to regarding this account? (Please List)
_____
(Due to HIPPA we will not speak with anyone not listed.)

Responsible Party (if different than patient):

First Name: _____ Last: _____ MI: _____ Preferred Name: _____

Birth Date: _____ Age: _____ SS#: _____ Drivers Lic: _____

Address: _____ City: _____ St: _____ Zip:_____

Cell Phone: _____ Work Phone: _____ Ext:_____ Hm. Phone: _____

Email: _____

Fill Out If Insurance Will Be Billed

Primary Insurance Information:

Subscriber Name: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Subscriber SS#: _____

Employer: _____

Insurance Company: _____

Member ID#: _____

Group #: _____

Secondary Insurance Information:

Subscriber Name: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Subscriber SS#: _____

Employer: _____

Insurance Company: _____

Member ID#: _____

Group #: _____

WHOM MAY WE THANK FOR REFERRING YOU/HOW DID YOU HEAR ABOUT US? _____