Patient Registration

Patient Information

Date _________________

Name: ____________________________________ __________ Preferred Name: ______________________
Last First MI

Mailing Address: _______________________________________ ____________________________________
Street Address Mailing Address / PO Box

____ Drivers Lic: ___________________________
City State Zip

Birthday: _______________________ Social Security #: ___________________________

Phone #: (______)________________ Cell #: (____)___________________ Work #:(_____)___________________

Preferred daytime contact? Home Cell Work

Gender: Male Female Marital Status: Married Divorce Single Separated Widowed

Student Status: Full time Part time Employment Status: Full time Part time Retired

Email: ______________________________________ May we use this for appointment reminders? Y or N

Emergency contact

Name:_________________________ No.: ___________________________ Relationship:_____________________

Responsible Party Information

Name: ____ Employer: _________________________
Last First MI

Mailing Address: _______________________________________ Birthday:_________________________
Mailing / Street Address

____ SS#: ___________________________
City State Zip

Phone #: (_____)___________________ Cell #: (____)___________________ Work#: (____)_____________________

Preferred daytime contact? Home Cell Work

Primary Insurance Information

Relationship to Insured: Self Spouse Child Other

Insurance Co.: ________________________ Employer:____________________ Group #: _____________________

______________________________ ______________________ ______________________________
Name of Policy Holder Policy Holder DOB Policy Holder SS#

____ ______________________________
Policy Holder Address Policy Holder member ID#

____
City State Zip

Secondary Insurance Information

Insurance Co.: _________________________ Employer:____________________ Group #: ___________________

______________________________ ______________________ ______________________________
Name of Policy Holder Policy Holder DOB Policy Holder SS#

____ ______________________________
Policy Holder Address Policy Holder member ID#

____
City State Zip