

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____
Patient's Name (Last) _____ (First) _____ (Middle) _____
Also Known As Name (Last) _____ (First) _____
Marital Status Married Single Divorced Widowed Legally Separated Other
Social Security Number _____ - _____ - _____ Female Male Date of Birth ___ / ___ / ___
E-mail Address _____
Phone Numbers Home _____ Day Evening Work _____ Day Evening
Cellular _____ Pager _____
Address _____
City, State, ZIP (+4) _____
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer _____ Occupation _____
Emergency Contact Name _____ Phone Number _____
Patient Relationship to Emergency Contact _____

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name (Last) _____ (First) _____ (Middle) _____
Also Known As Name (Last) _____ (First) _____
Social Security Number _____ - _____ - _____ Female Male Date of Birth ___ / ___ / ___
E-mail Address _____
Phone Numbers Home _____ Day Evening Work _____ Day Evening
Address _____
City, State, ZIP (+4) _____
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer _____ Employer Phone Number _____
Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____
Insurance Company/Phone Number _____ (_____) _____
Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____
Effective Date _____ Termination Date _____
Social Security Number _____ - _____ - _____ Female Male Insured Date of Birth ___ / ___ / ___
E-mail Address _____
Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____
Insurance Company/Phone Number _____ (_____) _____
Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____
Effective Date _____ Termination Date _____ Female Male
Insured Date of Birth ___ / ___ / ___ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____