Patient Registration Form

Today's date: ____________________ Please tell us how you heard about us: _________________ Referred By: _____________

PATIENT INFORMATION: *(Please use full legal name, no nicknames)*

First Name: ____________________ Last Name: ____________________ Middle I: ________

Preferred Name: ____

Address: ____

City: ____________________ State: _________ Zip: ____________________

Home Phone: #: ____________________ Cell Phone #: ____________________

Date of Birth: ____________________ Age: ______ Social Security #: ____________________

Male ________ Female: ________ Marital Status: ____________ Driver Lic #: ____________________

Employer Name and Address: ____ Work Phone #: ____________________

EMAIL ADDRESS: ____

RESPONSIBLE PARTY INFORMATION: ***(List person or insured name responsible for bill-use full legal name)***

Relationship to Patient: Self ______ Spouse _______ Parent ________ Other ________

First Name: ____________________ Last Name: ____________________ Middle I: ________

Address: ____

City: ____________________ State: _______________ Zip: _______________

Home Phone: #: ____________________ Cell Phone #: ____________________

Date of Birth: ____________________ Age: ________ Social Security #: ____________________

INSURANCE INFORMATION: *(Please allow receptionist to photocopy your Insurance ID cards)*

PRIMARY INSURANCE:

Plan Name: ____________________ Policy Holders Name: ____________________

Policy Holder's Employer Name ____

Policy Holder SSN: ____________________ Policy Holders DOB: ____________________ Effective date: __________________

Policy ID#: ____________________ Group# ____________________ Insurance Carrier Phone #: ____________________

SECONDARY INSURANCE:

Plan Name: ____________________ Policy Holders Name: ____________________ Policy Holders DOB: _________________

Policy Holder's Employer Name ____

Policy Holder SSN: ____________________ Effective date: __________________

Policy ID#: ____________________ Group# ____________________ Insurance Carrier Phone #: ____________________