PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

1.PATIENT NAME____________________, __________________, _____DATE OF BIRTH______/______/_____ SEX: M F

LAST FIRST MI

2. ADDRESS_______________________________________, _____________________________________, _________,

3. HOME PHONE: (______)_____________________ WORK: (_______)__________________CELL: (____)___________

4. EMAIL Address ____

5. SOC. SEC. NUMBER__________-_________-___________ MARITAL STAUS: ___ Married __ Single ___Widowed

6. EMPLOYMENT: ___Employed ___Unemployed ___Retired ____Other EMPLOYER:______________________________

7. PRIMARY INSURANCE CO:_________________ ID #___________________ GROUP #______________________

8. IF INSURANCE IS THROUGH SOMEONE OTHER THAN PATIENT, THEIR NAME _______________________________

9. THEIR BIRTHDATE: ______/______/_______ THEIR SOC. SEC. # ____

10. WHAT IS THEIR RELATIONSHIP TO PATIENT? _____Spouse ______Parent ______OTHER

11. THEIR ADDRESS, if different from patient: ____________________________, ___________________________,

THEIR

12. HOME PHONE:(______)____________________ WORK: (_______)_________________CELL: (_____)___________

13. CELL:

14. IF INSURANCE IS THROUGH AN EMPLOYER, WHO IS THE EMPLOYER? _________________________________ EMPLOYERS

ADDRESS: ____

15. OTHER INSURANCE? YES NO IF NO, SKIP TO EMERGENCY CONTACT INFORMATION SECTION

IF YES, INSURANCE CO:___________________ID#:___________________GROUP#___________________

IF INSURANCE IS **THROUGH** SOMEONE OTHER THAN PATIENT, THEIR NAME: _________________________

THEIR BIRTHDATE: ______/______/_______ THEIR SOC. SEC. #:_____________________________________

WHAT IS THEIR RELATIONSHIP TO PATIENT?___ Spouse___ Parent __Other

16. PRIMARY PHYSICIAN'S NAME / ADDRESS / PHONE:

____

____

17. WHO REFERRED YOU TO THIS OFFICE?

____

EMERGENCY CONTACT INFORMATION:

NAME: ____ RELATIONSHIP TO PATIENT:_____________________

ADDRESS____, __________________, _________. ____________

HOME PHONE: (______)___________________ WORK: (_______)___________________CELL: (____)____________

I understand that I am financially responsible for all charges for services provided to me. I authorize payment of medical benefits to myself or the names provided for professional services rendered. I authorize the release of any medical information necessary to process my claims.

____ _________________ _________________________________

Patient Signature Date Printed Name