PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name:_____ Middle Initial:_____

Preferred Name:_____ Patient Is: ☐ Policy Holder ☐ Responsible Party

Address:_____ Address 2:_____

City, State, Zip: _____

Birth Date:_____ Age:_____ Social Security Number: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Sex: ☐ Male ☐ Female

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Email:_____

Would you like to be contacted via email? ☐Yes ☐No

Would you like us to provide you with appointment reminders? ☐Yes ☐No

If yes, which method(s) do you prefer: ☐ Home ☐ Work ☐ Cell ☐ Email

Emergency Contact:

Name:_____

Relation to Patient:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Responsible Party (if someone other than the patient) – responsible for financial obligations

First Name: _____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City, State, Zip: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Birth Date:_____ Age:_____

☐ Responsible Party is also the Policy Holder for Patient

Primary Insurance/Policy Holder Information

Name of Policy Holder:_____ Contact Number:_____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Soc. Security Number: _____ Birth Date:_____

Subscriber ID:_____

Employer: _____ Ins. Company:_____

Phone Number:_____ Phone Number:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____