

PATIENT REGISTRATION

First Name: _____ *Last Name:* _____

Patient is: _____ Policy Holder _____ Responsible Party

Patient Information:

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State/ Zip: _____ Pager: _____

Home phone: _____ Work Phone: _____ ext. _____ Cellular: _____

Sex: ___ Male ___ Female Marital Status: ___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

Birth Date: _____ Age: _____ Social Security #: _____ Drivers Lic #: _____

E-mail: _____ If you would like to have correspondences via email please sign below. Please understand that information can be intercepted over the internet. Only your name date and time of appointment will be given.

Signature: _____ Date: _____

Responsible Party(if someone other than patient):

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ ext. _____ Cellular: _____

Birth Date: _____ Social Security #: _____ Drivers Lic. #: _____

_____ Responsible party is also a Policy Holder for Patient _____ Primary Insurance _____ Secondary Insurance

Primary Insurance Information:

Name of Insured: _____ Relationship to patient: (circle) self spouse child other

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Address: _____

City, State, Zip: _____

Insurance Company Name: _____

Group Number: _____ Policy Holders Identification Number: _____

Address: _____ Phone Number: _____

Remaining Benefits: _____ Remaining Deductible: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to patient: (circle) self spouse child other

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Address: _____

City, State, Zip: _____

Insurance Company Name: _____

Group Number: _____ Policy Holders Identification Number: _____

Address: _____ Phone Number: _____

Remaining Benefits: _____ Remaining Deductible: _____

We try to call our patients to confirm appointments at least the day before. Please sign below if you consent for us to leave reminders with family members or on you answering machine reminding you of your appointment: sign: _____