Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ 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 Work____________________ ☐ Day ☐ Evening Home___________________ ☐ 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__________________________

Emergency Contact Relationship to Patient____

Referring Provider Name____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____________________ (First)_______________________ (Middle)__________________

Also Known As Name (Last)____(First)_______________________________________

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/_______

E-Mail Address____

Phone Numbers Work____________________ ☐ Day ☐ Evening Home___________________ ☐ 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____________________

Insured Employer Name____

Insurance Company/Phone Number____ (______)_________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount____________________

Effective Date____________________ Termination Date_____________________ ☐ Female ☐ Male

Insured Date of Birth______/______/_______ Insured's Social Security Number _______-_____-_______

Insurance Company Address____

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

Name of Insured____ Patient Relationship to Insured____________________

Insured Employer Name____

Insurance Company/Phone Number____ (______)_________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount____________________

Effective Date____________________ Termination Date_____________________ ☐ Female ☐ Male

Insured Date of Birth______/______/_______ Insured's Social Security Number _______-_____-_______

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***_______________