PATIENT REGISTRATION FORM

Date _____

Patient Information (Confidential)

NAME _____ DATE OF BIRTH _____
First MI Last

ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP_____

SOC. SEC. # _____ E-MAIL _____ HOME # _____ CELL # _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY? _____ PHONE: _____ RELATION:_____

Responsible Party

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SOC. SEC. # _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

Insurance information

NAME OF INSURED_____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ INS PHONE _____ GROUP _____ ID # _____

HAVE YOU USED YOUR INSURANCE THIS YEAR? ☐ YES ☐ NO

Do you have any additional insurance? ☐ YES ☐ NO **If yes, complete the following:**

NAME OF INSURED_____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ INS PHONE _____ GROUP _____ ID # _____

HAVE YOU USED YOUR INSURANCE THIS YEAR? ☐ YES ☐ NO

_____

SIGNATURE OF PATIENT OR PARENT IF MINOR