NEW PATIENT REGISTRATION

Patient Information

First Name_____ Last Name_____

Preferred Name_____ Date of Birth_____ Sex: ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Soc. Sec #._____ Driver's License #_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Emergency Contact _____ Phone_____

How would you like to receive appointment reminders and correspondence? ☐ Email ☐ Text Message ☐ Personal Phone Call

Is the patient responsible for payments? ☐ Yes ☐ No

Responsible Party (if other than patient)_____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Responsible Party ****Please fill out this section if patient is NOT responsible party****

First Name_____ Last Name_____

Address_____ City_____ State_____ Zip_____

Employer_____ City_____ State_____ Zip_____

Soc. Sec #._____ Driver's License #_____ Date of Birth_____

Home Phone_____ Work Phone_____ Cell Phone._____

Primary Insurance	**Secondary Insurance**
Policyholder Name_____	Policyholder Name_____
SSN or Member ID#_____	SSN or Member ID#_____
Policyholder Address (if different from patient's)	Policyholder Address (if different from patient's)
_____	_____
Ins. Company_____	Ins. Company_____
Group #_____	Group #_____
Employer_____	Employer_____