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PATIENT REGISTRATION

PATIENT INFORMATION

☐ Jr ☐ Sr ☐ Other

Patient Name Last _____ **First** _____ **Middle** _____
Nickname/Other: _____
Gender: ☐ Female ☐ Male **Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other
SS#: _____ **DOB:** _____
Tel: **Home**: _____ ☐ Day ☐ Evening **Work**: _____ ☐ Day ☐ Evening
Mobile: _____ **Pager**: _____
Address: _____
City/State/Zip(+4): _____
Employment: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed
Employer: _____ **Occupation**: _____
Emergency Contact Name (First, Last): _____ **Telephone**: _____
Patient Relationship to Emergency Contact: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Last _____ **First** _____ **Middle** _____
Nickname/Other: _____
SS#: _____ **DOB:** _____
Tel: **Home**: _____ ☐ Day ☐ Evening **Work**: _____ ☐ Day ☐ Evening
Mobile: _____ **Pager**: _____
Address: _____
City/State/Zip(+4): _____
Employment: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed
Employer: _____ **Occupation**: _____
Emergency Contact Name (First, Last): _____ **Telephone**: _____
Patient Relationship to Emergency Contact: _____

PRIMARY INSURANCE INFORMATION (At check in, please present your insurance card to front desk receptionist)

Name of Insured: _____ **Patient Relationship to Insured**: _____
Insurance Company: _____ **Tel** (include AC): _____
Policy Number: _____ **Group Number**: _____ **Co-pay Amt**: $ _____
Effective Date: _____ **Termination Date**: _____ ☐ Female ☐ Male
Insured DOB: _____ **Insurance Company Address**: _____
City/State/Zip (+4): _____

SECONDARY INSURANCE INFORMATION (At check in, please present your insurance card to front desk receptionist)

Name of Insured: _____ **Patient Relationship to Insured**: _____
Insurance Company: _____ **Tel** (include AC): _____
Policy Number: _____ **Group Number**: _____ **Co-pay Amt**: $ _____
Effective Date: _____ **Termination Date**: _____ ☐ Female ☐ Male
Insured DOB: _____ **Insurance Company Address**: _____
City/State/Zip (+4): _____

SIGNATURE INFORMATION

I agree that the information supplied on this Patient Registration is accurate and up-to-date to the best of my knowledge.

_____ _____
Patient/Responsible Party Signature **Date**: