Patient Registration Form

Date: _____

Last Name _____ First Name:_____ Middle Initial____

Address _____ City_____ St_____ Zip_____

Home Phone (____)_____ Cell (_____)_____ Work (_____)_____ext _____

Sex: M F Date of Birth ____/____/_____ SS#_____ Drivers License #_____

Email Address _____ Occupation: _____

Name of Employer/ School _____ Full Time ( ) / Part Time ( )
Status: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated
Responsible Party: ( ) Self ( ) Parents* ( ) Legal Guardian – Power of Attorney* (*Must complete next section below)

Parent or Legal Guardian Information:

Guardian/Father's Name: _____ Date of Birth _____
Address _____ City_____ St_____ Zip_____

Home Phone (____)_____ Cell (_____)_____ Work (_____)_____ext_____
SS#_____ Drivers License #:_____ Employer:_____

Mother's Name: _____ Date of Birth _____
Address _____ City_____ St_____ Zip_____

Home Phone (____)_____ Cell (_____)_____ Work (_____)_____ext _____
SS#_____ Drivers License #_____Employer_____

Who is responsible for your bill?_____
Who Brought you in today: ( ) Father ( ) Mother ( ) Legal Guardian ( ) Other, Grandparent etc.

Insurance Information

Primary Insurance Co Name: _____ ID#:_____

Group# _____ SS# _____ Telephone: (____)_____ ext _____

Policy Holder Name:_____ DOB: _____ Relationship:_____

Employer Name:_____ Telephone #_____

Flex Account: ( ) Yes, Ok to use ( ) No Flex Account #_____ Expiration: _____

Secondary Insurance Co Name: _____ ID#:_____

Group # _____SS# _____ Telephone (____) _____ext_____

Policy Holders Name: _____ DOB: _____ Relationship: _____

Employer Name: _____ Telephone (_____) _____

Emergency Contact / Referral Information:

Name _____ Telephone: (____)_____Relationship_____
If Referred, who referred you: _____
Additional Family Members who come here:_____
Primary Care Physician:_____ Telephone: _____