PATIENT REGISTRATION

*Date:*____________________________

*First name:*______________________________ *Last name:*_______________________________ *Middle Initial:*_______

*Preferred name:*________________________

Responsible party (if someone other than the patient)

*First name:*________________________________ *Last name:*_______________________________ *Middle Initial:*_______

*Address:*____

*City, State, Zip*____

*Home phone:*____________________ *Work phone:*__________________ *Ext:*______ *Cell phone:*_________________

*Birthdate:*_______________ *Soc. Sec:*________________________ *Drivers Lic:*____________________

Patient Information

*Address:*____ *City, State, Zip*_______________________________

*Home phone:*___________________ *Work phone*__________________ *Ext:*______ *Cell phone:*_____________________

Sex: male ☐ *Female* ☐ *Birth date:*____________ *Age:*______ *Soc. Sec.* ___________________ *Drivers Lic:*_______________

Marital Status: Married ☐ *Single* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* ☐ *Email Address;*_________________________________

I would like to receive correspondence via email: yes ☐ *no* ☐

I would like to receive appointment confirmations via text messages: yes ☐ *no* ☐

Primary Insurance Information

*Policy Holder name:*____ *Relationship to patient: Self c Spouse cChild cOtherc*

*ID#:*_____________________________ *Policy holders birthdate:*_________________ *Employer:*________________________

*Ins. Co.:*____________________________ *Address:*_______________________ __*City, State, Zip:*________________________

*Ins. Phone:*_____________________________________

Secondary Insurance Information

*Policy Holder name:*____ *Relationship to patient: Self c Spouse cChild cOtherc*

*ID#:*_____________________________ *Policy holders birthdate:*_________________ *Employer:*________________________

*Ins. Co.:*____________________________ *Address:*_______________________ __*City, State, Zip:*________________________

*Ins Phone:*_______________________________________