Patient Registration

Patient Information

First Name:______________________ Last Name:______________________

Preferred Name:______________________ Birth Date:______________________

Address:______________________ City, State & Zip Code:______________________

Phone:______________________ Secondary Phone:______________________

Email:______________________ Male: ○ Female: ○ Social Security Number:______________________

Status: Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Child ○

Patient is Responsible Party: Yes/No Is Primary Insurance Policy Holder: Yes/No Is Secondary Insurance Policy Holder: Yes/No

Responsible Party Information (If someone other than patient)

First Name:______________________ Last Name:______________________

Preferred Name:______________________ Birth Date:______________________

Address:______________________ City, State & Zip Code:______________________

Phone:______________________ Secondary Phone:______________________

Email:______________________ Male: ○ Female: ○ Social Security Number:______________________

Status: Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Child ○

If you have your insurance card(s) with you, please present to the receptionist at this time for photocopying. You may then skip the next section. If you do not have your card(s) with you, please fill out the next section fully.

Primary Insurance Information

Subscriber:______________________ Subscriber Birth Date:______________ Group Number:______________

Subscriber ID:______________ Employer:______________________ Insurance Company:______________________

Insurance Phone:______________________ Insurance Address:______________________

Secondary Insurance Information

Subscriber:______________________ Subscriber Birth Date:______________ Group Number:______________

Subscriber ID:______________ Employer:______________________ Insurance Company:______________________

Insurance Phone:______________________ Insurance Address:______________________

We like to thank those who refer patients to our office. Please let us know how you were referred to our office.

____