Patient Registration Form

Patient's Name (Last, First, MI): ____

Patient's Home Phone Number: ____________________ Alternate Phone Number (☐ cell or ☐ work): ________________________

E-Mail Address: ____

Address: ____ Apt. # ___________

City: ______________________________ State: ________________ Zip: _______________

Date of Birth: ____-____-_______ Age: ______ Sex: M F Social Security Number: _________________________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: __________________________

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired [ ] Student [ ] Other: _________________

Emergency Contact: ____ Relationship to Patient: __________________________

Address: ____ Phone number: ______________________

INSURANCE INFORMATION

Primary Insurance: ___________________

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: ___________________

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _______________________________________ Relationship to Patient: ______________________

Address: ____

Social Security Number: _______________________________

Date of Birth: ____

His or Her Employer: __________________________________ Work Phone Number: _______________________________

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): ____ Relationship to Patient: ________________________________

Patient / Parent or Guardian Signature: ____ Date: ___________________