

**Patient Registration Form**

(Please Print)

**PATIENT INFORMATION**

Dr.  Mr.  Mrs.  Ms.  Jr.  Sr.  Other\_\_\_\_\_

Patient's Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_ (Middle)\_\_\_\_\_

Also Known As Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address\_\_\_\_\_

Phone Numbers Work\_\_\_\_\_  Day  Evening Home\_\_\_\_\_  Day  Evening  
Cellular\_\_\_\_\_ Pager\_\_\_\_\_

Address\_\_\_\_\_

City, State, ZIP (+4)\_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer\_\_\_\_\_ Occupation\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_ Phone Number\_\_\_\_\_

Emergency Contact Relationship to Patient\_\_\_\_\_

Referring Provider Name\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_ (Middle)\_\_\_\_\_

Also Known As Name (Last)\_\_\_\_\_ (First)\_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address\_\_\_\_\_

Phone Numbers Work\_\_\_\_\_  Day  Evening Home\_\_\_\_\_  Day  Evening

Address\_\_\_\_\_

City, State, ZIP (+4)\_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer\_\_\_\_\_ Employer Phone Number\_\_\_\_\_

Patient Relationship to Responsible Party\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured\_\_\_\_\_ Patient Relationship to Insured\_\_\_\_\_

Insured Employer Name\_\_\_\_\_

Insurance Company/Phone Number\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_

Subscriber ID (Policy Number)\_\_\_\_\_ Group ID\_\_\_\_\_ Copay Amount\_\_\_\_\_

Effective Date\_\_\_\_\_ Termination Date\_\_\_\_\_  Female  Male

Insured Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company Address\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured\_\_\_\_\_ Patient Relationship to Insured\_\_\_\_\_

Insured Employer Name\_\_\_\_\_

Insurance Company/Phone Number\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_

Subscriber ID (Policy Number)\_\_\_\_\_ Group ID\_\_\_\_\_ Copay Amount\_\_\_\_\_

Effective Date\_\_\_\_\_ Termination Date\_\_\_\_\_  Female  Male

Insured Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company Address\_\_\_\_\_

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

**Patient (or Responsible Party) Signature**\_\_\_\_\_ **Date**\_\_\_\_\_