Patient Registration Form

Date:_____

Name:_____ Nickname:_____

Address:_____ City:_____ State:____ Zip:_____

Hm:(____)_____ Cell:(_____)_____ Wrk:(____)_____

Check Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Date of Birth:_____ SSN:_____ Employer:_____

Email Address:_____ **(for appointment reminders)**

Whom may we thank for referring you?_____

Emergency contact:

Name:_____ Phone:_____ Relationship:_____

College Students: (who are covered under parents insurance)

School Name:_____ **City/State:**_____ ☐ **FT** ☐ **PT**

Responsible Party-Insurance Information:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Date of Birth:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone:(____)_____

Employer:_____ Responsible Party SSN:_____

Insurance Company Name:_____ ID#:_____

Responsible Party-Secondary Insurance Information:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Date of Birth:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone:(____)_____

Employer:_____ Responsible Party SSN:_____

Insurance Company Name:_____ ID#:_____