PATIENT REGISTRATION

------Patient Information----------

First Name: _____ Last: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ Address 2:_____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ ☐ I would like to receive appointment reminder text messages

Birth Date: _____ Age: _____ ☐ Male ☐ Female Social Security #:_____

E-mail:_____ ☐ I would like to receive correspondences via e-mail

------Responsible Party (If someone other than the patient) ----------

This should be the parent who brought in the child, if applicable

First Name: _____ Last Name: _____ Middle initial: _____

Address: _____ Address 2:_____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____

------Primary Insurance Information------A copy of your insurance card will be requested---------

If policy holder is not listed on this form, we will need that person's address as well

Name of policy holder: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insured Social Security #: _____ Insured Date of Birth: _____

Employer: _____

Subscriber ID#: _____ Group #: _____

------Secondary Insurance Information----------

Name of policy holder: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Subscriber ID#: _____ Group #: _____

------Emergency Contact Information----------

Name of emergency contact _____ Relationship to you: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____