PATIENT REGISTRATION

Patient Information

First Name: ______________________ MI: ______ Last Name: ______________________

Preferred Name: ______________________ Sex: ○ Male ○ Female

Birth Date: ______________________ SS#: ______________________

Street and mailing address: ______________________

City, State, Zip: ______________________

Home Phone: ______________ Cell Phone: ______________ May we contact you by text? ○ Yes ○ No

Email: ______________________ May we contact you by email? ○ Yes ○ No

Employer: ______________________ Work Phone: ______________________

Spouse's First Name: ______________ MI_____ Last Name: ______________________

Spouse's date of birth: ______________ SS# ______________________

Spouse's employer ______________________ Spouse's work # ______________________

How did you hear about our office? ______________________

EMERGENCY CONTACT: ______________________

RELATIONSHIP: ______________________

CONTACT PHONE #: ______________________

Responsible Party (if patient is **under 18**)

First Name: ______________________ MI: _______ Last Name: ______________________ ________

Address: ______________________

City, State, Zip: ______________________ ___

Home Phone: ______________________ Cell Phone: ______________________

Birth Date: ______________________ SS#: ______________________

Employer ______________________ Work Phone: ______________________

Spouse's First Name: ______________ MI_____ Last Name: ______________________

Spouse's date of birth: ______________ Spouse's SS# ______________________

Spouse's employer ______________________ Spouse's work # ______________________

Primary Insurance Information – Policy Holder Information (please present card)

Name of Policy Holder: ______________________

Address: ______________________

Phone Number: ______________________ Patients relationship to Insured: Spouse Child Other Self

SS#: ______________________ Birth Date: ______________________

Employer: ______________________ ______________________

Ins. Company: ______________________ Phone Number of Insurance Co. ______________________

Address of Insurance Co. ______________________

Group #: ______________________ Member ID#: ______________________