FAMILY REGISTRATION

Responsible Party

First Name: _____ Middle Initial: ____ Last Name: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____ Can we contact you via text? ○ Yes ○ No

Sex: ○ Male ○ Female

Birth Date: _____ SS#: _____

Email: _____ Can we contact you via email? ○ Yes ○ No

How did you hear about our office?_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

CONTACT PHONE #: _____

Family Members (besides responsible party, who will become patients here or have been seen in our office in the past)

First Name: _____ M: ____ Last: _____ Birth Date: _____

Preferred Name:_____ Phone #_____ Relationship: ○ Spouse ○ Child

First Name: _____ M: ____ Last: _____ Birth Date: _____

Preferred Name:_____ Phone #_____ Relationship: ○ Spouse ○ Child

First Name: _____ M: ____ Last: _____ Birth Date: _____

Preferred Name:_____ Phone #_____ Relationship: ○ Spouse ○ Child

First Name: _____ M: ____ Last: _____ Birth Date: _____

Preferred Name:_____ Phone #_____ Relationship: ○ Spouse ○ Child

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

Name of Policy Holder _____

SS# (used to identify insured): _____

Birth Date: _____

Employer: _____

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

Address of Insurance Co. _____

Group #: _____ Member ID#: _____

Does this cover ALL family members? ○ Yes ○ No