PATIENT REGISTRATION FORM

*** Today's Date:* ______________________ *Clinic Name:* ______________________

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: ______________________ *First Name: ______________________ Middle Initial: ________

*Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone #: (______) ________-__________ *Social Security #: ______________________

*Date of Birth: ______________ Age: ______ *Sex: ______ Marital Status: ______ Drivers Lic# __________

*Employer Name and Address: ____

____ Work Phone #: (______) ________-__________

E-mail Address: ______________________________ Cell Phone #: (______) ________-__________

Emergency Contact Name: ______________________________ Emergency Phone # (______) ________-__________

Please tell us how you heard about us: ______________________ *Referred by:* ______________________

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)

* Relationship of Guarantor to Patient: Self ______ Spouse ______ Parent ______ Other ______________

*Last Name: ______________________ *First Name: ______________________ Middle Initial: ________

*Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone #: (______) ________-__________ *Social Security #: ______________________

*Date of Birth: ______________ Age: ______ *Sex: Female ________ Male ________

*Employer Name and Address: ____

____ Work Phone #: (______) ________-__________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLDUE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: ______________________ *Insured's Name: ______________________

Insured's Social Security #: ______________________ *Insured's Date of Birth: ______________________

*Policy / ID #: ______________________ *Group #: ______________________ Eff Date: ______________

Claims Address & Phone: ____

SECONDARY INSURANCE:

Plan Name: ______________________ *Insured's Name: ______________________

Insured's Social Security #: ______________________ *Insured's Date of Birth: ______________________

*Policy / ID #: ______________________ *Group #: ______________________ Eff Date: ______________

Claims Address & Phone: ____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS

Please read and sign back of form.