Registration

PATIENT INFORMATION *(CONFIDENTIAL)*

NAME: ______________________ (FIRST / MI / LAST) DATE: ________

ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

EMAIL: ________ CELL PHONE: ________ HOME PHONE: ________

SS#/SIN: ________ BIRTH DATE: ________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL: ________ CITY: ________ STATE: ____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER: ________ WORK PHONE: ________

BUSINESS ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

SPOUSE OR PARENT'S/GUARDIAN'S NAME: ________ EMPLOYER: ________ WORK PHONE: ________

WHOM MAY WE THANK FOR REFERRING YOU? ________

PERSON TO CONTACT IN CASE OF AN EMERGENCY: ________ PHONE: ________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: ________ RELATIONSHIP TO PATIENT: ________

ADDRESS: ________ HOME PHONE: ________

DRIVERS LICENSE #: ________ BIRTH DATE: ________ SS#/SIN: ________

EMPLOYER: ________ WORK PHONE: ________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED: ________ RELATIONSHIP TO PATIENT: ________

BIRTH DATE: ________ SS#/SIN: ________ DATE OF EMPLOYED: ________

NAME OF EMPLOYER: ________ UNION OR LOCAL #: ________ WORK PHONE: ________

EMPLOYER ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

INSURANCE CO.: ________ TEL. #: ________ GRP. #: ________ POLICY / I.D. #: ________

INS. CO. ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

HOW MUCH IS YOUR DEDUCTIBLE? ____ HOW MUCH HAVE YOU USED? ____ MAX ANNUAL BENEFIT? ____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED: ________ RELATIONSHIP TO PATIENT: ________

BIRTH DATE: ________ SS#/SIN: ________ DATE OF EMPLOYED: ________

NAME OF EMPLOYER: ________ UNION OR LOCAL #: ________ WORK PHONE: ________

EMPLOYER ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

INSURANCE CO.: ________ TEL. #: ________ GRP. #: ________ POLICY / I.D. #: ________

INS. CO. ADDRESS: ________ CITY: ________ STATE: ____ ZIP: ____

HOW MUCH IS YOUR DEDUCTIBLE? ____ HOW MUCH HAVE YOU USED? ____ MAX ANNUAL BENEFIT? ____

X ______________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

____
PATIENT NUMBER