PATIENT REGISTRATION

Patient's name ______________________ Birth Date __________

Name of spouse/partner/parent ______________________ Birth Date __________

Home phone ______________ Cell phone ______________

Street address ______________________

- Single ☐
- Widowed ☐
- Married ☐
- Long Term Partner ☐
- Divorced ☐
- Separated ☐

City ______________________ State __________ Zip __________

Patient employed by ______________________ Phone __________

Business address ______________________

Present position ______________________ How long held __________

Spouse/partner employed by ______________________ Phone __________

Business address ______________________

Present position ______________________ How long held __________

In case of emergency, who should be notified ______________________ Phone __________

Person responsible for this account ______________________

Patient's Social Security Number if over 18 ______________________

Driver's License number ______________________

Spouse/partner's/parent Social Security Number ______________________

Spouse/partner's/parent Driver's License Number ______________________

Who may we thank for referring you ______________________

Purpose of this appointment ______________________

INSURANCE INFORMATION

If you have insurance, name of insured ______________________ Date of birth __________

Name of insurance company ______________________ Policy no. __________

Insured relationship to patient ______________________

Address if different from patient ______________________

Additional Insurance:

Name of insured ______________________ Date of birth __________

Name of insurance company ______________________ Policy no. __________

Insured relationship to patient ______________________

Signature ______________________ **Date** __________