

# Patient Registration Form

Today's Date \_\_\_\_\_ Appointment With \_\_\_\_\_ Acct# \_\_\_\_\_

## Patient Information

Legal First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip Code*

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Social Security Number \_\_\_\_\_ **OR** Drivers License Number \_\_\_\_\_

Primary Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender: M / F Marital Status: Married / Single / Divorced

Referred By \_\_\_\_\_ Primary/Family Physician \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
*Name Relationship Address Phone*

## Responsible Party (if other than patient) and Billing Information

Legal First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip Code*

Relationship to Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Drivers License Number \_\_\_\_\_ Employer \_\_\_\_\_

Primary Email Address \_\_\_\_\_

## Insurance Information

PRIMARY Insurance Company \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip Code*

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_

SECONDARY Insurance Company \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip Code*

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_