Patient Registration

First Name:______________________________ Middle Initial:______ Last Name:_____________________________

Patient Is: ☐ Policy Holder Preferred Name:________________________

☐ Responsible Party

Patient Information:

Address:____ Address2:_____________________________________

City, State, Zip:____

Home Phone:______________ Work Phone:____________________ Ext:_________ Cellular:_________________

Sex: Male/Female Marital Status:___________________________ Spouses Name:_____________________

Birth Date:_________________ SSN:_____________________

E-Mail:____

I prefer to receive appointment reminders:Home Work Cellular Text Email (check all that apply)

Whom should we thank for referring you?____

Responsible Party (if someone other than the patient):

First Name:______________________________ Last Name:_____________________________ Middle Initial:______

Address:____ Address 2:_____________________________________

City, State, Zip:____

Home Phone:______________ Work Phone:____________________ Ext:_________ Cellular:_________________

Birth Date:_________________ SSN:_____________________

○ Primary Insurance Policy Holder

○ Secondary Insurance Policy Holder

Primary Insurance Information:

Name of Insured:______________________________________ Relationship to Insured:________________________

Insured Member ID (or SSN):__________________________________ Insured Birth Date:______________________

Group #:__________________________ Employer:____

Insurance Company:____________________________________

Address:____ Phone:___________________________________

Address2:____

City, State, Zip:_______________________________________

Secondary Insurance Information:

Name of Insured:______________________________________ Relationship to Insured:________________________

Insured Member ID (or SSN):__________________________________ Insured Birth Date:______________________

Group #:__________________________ Employer:____

Insurance Company:____________________________________

Address:____ Phone:___________________________________

Address2:____

City, State, Zip:_______________________________________

Clear Form