REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Birthdate: / / Age: Sex: ☐ M ☐ F

Mailing Address: Preferred Phone: Alternate Phone: Social Security No.:

City: State: Zip:

Email:

Employer:

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Social Media

☐ Website ☐ Family ☐ Friend ☐ Advertisement ☐ Other _____

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Person responsible for bill: Birthdate: / / Address (if different): Phone:

Employer: Employer Address: Employer Phone:

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's Information

Legal Name: Social Security No.: Birthdate: / /

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please indicate **primary** insurance:

Policy No.: Group No.:

Does this patient have another insurance? ☐ Yes ☐ No

Legal Name of Other Subscriber: Social Security No.: Birthdate: / /

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please indicate **secondary** insurance:

Policy No.: Group No.:

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient:

Home phone: Cell phone: