

# PATIENT REGISTRATION FORM

**\*\*Today's Date:** \_\_\_\_\_ **Clinic Name:** \_\_\_\_\_

**PATIENT INFORMATION: (Please use full legal name, no nicknames)**

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

\*Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emerg Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Please tell us how you heard about us:* \_\_\_\_\_ *Referred by* \_\_\_\_\_

**GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)**

\*Relationship of Guarantor to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

\*Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)**

*IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*

**PRIMARY INSURANCE:**

Plan Name : \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_

\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

**SECONDARY INSURANCE:**

Plan Name : \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_

\*Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_

\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ \* Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

**\*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. \*ATTACH COPY OF INSURANCE CARDS.**

*Please read and sign back of form.*