PATIENT INFORMATION (CONFIDENTIAL)

NAME ______ DATE ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

E-MAIL ______ CELL PHONE ______ HOME PHONE ______

SS# ______ BIRTHDATE ______

CHECK APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ OTHER

IF COLLEGE STUDENT ☐ FT ☐ PT NAME OF SCHOOL ______ CITY ______ STATE ______

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER ______ WORK PHONE ______

BUSINESS ADDRESS ______ CITY ______ STATE ______ ZIP ______

SPOUSE/PARENT'S/GUARDIAN'S NAME ______ EMPLOYER ______ WORK PHONE ______

WHOM MAY WE THANK FOR REFERRING YOU ______

EMERGENCY CONTACT ______ PHONE ______

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR ACCOUNT ______ RELATIONSHIP ______

ADDRESS ______ HOME PHONE ______

DRIVER LIC # ______ BIRTHDATE ______ SS# ______

EMPLOYER ______ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______ RELATIONSHIP ______

BIRTHDATE ______ SS# ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE CO ______ TEL # ______ GRP # ______ POLICY/ID # ______

INS CO ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE ______ MAX ANNUAL BENEFIT ______ HOW MUCH HAVE YOU USED ______

DO YOU HAVE ADDITIONAL INSURANCE ☐ YES ☐ NO IF YES PLEASE COMPLETE THE FOLLOWING SECTION:

NAME OF INSURED ______ RELATIONSHIP ______

BIRTHDATE ______ SS# ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE CO ______ TEL # ______ GRP # ______ POLICY/ID # ______

INS CO ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOW MUCH IS YOUR DEDUCTIBLE ______ MAX ANNUAL BENEFIT ______ HOW MUCH HAVE YOU USED ______

____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

REGISTRATION