Patient Registration

Patient Information

First Name: _____ Last Name:_____ M.I._____
Preferred Name:_____
Birth Date: _____ Soc. Sec.# _____ Driver's Lic. # _____

Address: _____ Address 2: _____
City, State, Zip _____
Home Phone: _____ Work Phone: _____ Ext. _____ Cellular: _____
Email: _____
Preferred methods of correspondence: ○ Email ○ Text ○ Phone ○Before-noon ○ After-noon

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
I Identify my gender as: _____
Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Primary Insurance Information

Name of Insured: _____ **Relationship to Patient:** ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec.# _____ Insured Birth Date: _____
Employer: _____ Insurance Co. _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Phone #: _____ Phone #: _____

Secondary Insurance Information

Name of Insured: _____Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec.# _____ Insured Birth Date: _____
Employer: _____ Insurance Co. _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Phone #: _____ Phone #: _____

To the best of my knowledge the questions in this form have been accurately answered.

Signature of Patient, Parent, or Guardian _____ Date: _____