PATIENT REGISTRATION

First Name_____ **Last Name**: _____ **Middle Initial**: _____
Patient is… ( ) Policy Holder **Preferred Name**:_____
( ) Responsible Party

Responsible Party (if someone other than the patient)

First Name_____ **Last Name**: _____ **Middle Initial**: _____
Address: _____
City: _____ **State**_____ **Zip**_____
Home Phone: (____) _____**Work** :(____) _____**Ext**:_____ **Cellular** (____) _____
Sex: ( ) Male ( ) Female **Marital Status**: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Birth Date: ____/____/_____ **Soc Sec**: _____/____/_____ **Drivers Lic**: _____
Responsible Party is also a... ( )Policy Holder for Patient ( )Primary Ins. Holder ( )Secondary Ins. Holder

Patient Information

Address: _____
City: _____ **State**_____ **Zip**_____
Home Phone: (____) _____**Work** :(____) _____**Ext**:_____ **Cellular** (____) _____
Sex: ( ) Male ( ) Female **Marital Status**: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Birth Date: ____/____/_____ **Soc Sec**:_____/____/_____ **Drivers Lic**: _____
E-Mail:_____ ( ) I would like to receive correspondences via E-Mail
Employment Status: ( ) Full Time ( ) Part Time ( ) Retired
Student Status: ( ) Full Time ( ) Part Time

Primary Insurance Information

Name of Policy Holder: _____
Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other
Policy Holder Soc Sec: _____/____/_____ **Policy Holder Birth Date**: ____/____/_____
Employer:_____
Address: _____
City: _____ **State**_____ **Zip**_____
Insurance Company: _____
Address: _____
City: _____ **State**_____ **Zip**_____

Secondary Insurance Information

Name of Policy Holder: _____
Relationship to Policy Holder: ( ) Self ( ) Spouse ( ) Child ( ) Other
Policy Holder Soc Sec: _____/____/_____ **Policy Holder Birth Date**: ____/____/_____
Employer:_____
Address: _____
City: _____ **State**_____ **Zip**_____
Insurance Company: _____
Address: _____
City: _____ **State**_____ **Zip**_____