

PATIENT REGISTRATION

(Thank you for printing legibly.)

PATIENT INFORMATION

DATE _____

PATIENT NAME _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE NUMBERS WHERE WE MAY CONTACT YOU: Home _____
Cell _____
Work _____

DATE OF BIRTH _____ **AGE** _____ **SEX:** M F **SPOUSE'S NAME** _____

SOCIAL SECURITY # _____

EMERGENCY CONTACT		
Name	Relationship to Patient	Phone Numbers

RESPONSIBLE PARTY (Person responsible for billing and payment..)

NAME _____ **S.S. #** _____ **D/O/B:** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE NUMBERS WHERE WE MAY CONTACT RESPONSIBLE PARTY: Home: _____
Cell: _____
Work _____

RELATIONSHIP TO PATIENT: Self _____ Spouse _____ Child _____ Other _____

INSURANCE (Please provide this information AND present your card to the receptionist for photocopying.)

NAME OF INSURANCE CO. _____

INSURED (If different from patient) _____ **S.S. #** _____ **D/O/B:** _____

RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Other _____

SECONDARY INSURANCE (Please provide this information if applicable AND present your card to the receptionist for photocopying.)

NAME OF INSURANCE CO. _____

INSURED (If different from patient) _____ **S.S. #** _____ **D/O/B:** _____

RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Other _____

The foregoing information is required in order to properly bill your insurance company and/or responsible party. If the information provided is not available at the time of the appointment or proves to be inaccurate, you may be required to pay in full for services provided.

You will be asked at each visit to verify this information and to provide current insurance information. Thank you for your cooperation.

I verify that the information provided today is correct. _____
Patient/Guardian Date