Patient Registration Information

Patient Information

First Name: _____ Last Name: _____ M.I.: _____

Preferred Name: _____ Title (Mr., Mrs., Dr.): _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Text Messages OK? ☐Yes ☐No Preferred Number: ☐Home ☐Work ☐Cell

Email: _____ I would like correspondence via email: ☐Yes ☐No

Birth Date: _____ Social Security Number: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Child

Student status if dependent over 19 (for ins): ☐Nonstudent ☐Fulltime ☐Parttime School: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ M.I.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Text Messages OK? ☐Yes ☐No Preferred Number: ☐Home ☐Work ☐Cell

Email: _____ I would like correspondence via email: ☐Yes ☐No

Birth Date: _____ Social Security Number: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Child

Primary Insurance Information **Please present insurance card to receptionist.**

Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Subscriber Name: _____ Subscriber ID #: _____

Employer: _____ Group #: _____

Insurance Company: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____