PATIENT REGISTRATION FORM

Section I:
Name: _____ I prefer to be called: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Work Phone: _____ Cell Phone: _____

The best time to call me is: _____ ☐A.M ☐P.M (on my phone) ☐Home ☐ Work ☐ Cell
Date of Birth: _____ Social Security Number: _____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
If student, Name School: _____ City/State: _____ ☐FT ☐PT
Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____
Whom may we thank for referring you? _____
Person to contact in case of emergency: _____ Phone: _____

Section II:
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ ZIP: _____ Phone: _____
Employer: _____ Work Phone: _____ SSN: _____

Section III:
Name of Insured: _____ Dob: _____ Relationship to Patient: _____
SSN#: _____ Name of Employer: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: _____ ZIP: _____
Insurance Company: _____ Group#: _____ ID#:_____

ADMINISTRATIVE FEES

No Show Appointments	**$30.00**
Returned Checks	**$50.00**
Take out of Collections	**$50.00**

PLEASE SIGN ACKNOWLEDGING THAT YOU HEAVE READ AND UNDERSTAND THE ABOVE:

_____ _____
Patient or Responsible Party **Date**