

# Patient Registration

Acct. # \_\_\_\_\_ Doctor # \_\_\_\_\_ Date: \_\_\_\_\_

*(PLEASE COMPLETE IN INK)*

## PATIENT INFORMATION

Full Legal Name: \_\_\_\_\_ (\_\_\_\_\_)  
(Last) (First) (Middle) (Nickname)

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ S. S. #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ EMail Address: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_ Pager No.: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Employers Phone No.: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Employer's Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_ Contact: \_\_\_\_\_

## PHYSICIAN

### WHO REFERRED

YOU: Physician's Full Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

## PRIMARY

### INSURANCE

Patient's Relationship with Insured:

Insurance Carrier: \_\_\_\_\_  Self  Spouse  Dependent  Other

Subscriber's Name: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

## SECONDARY

### INSURANCE

Patient's Relationship with Insured:

Insurance Carrier: \_\_\_\_\_  Self  Spouse  Dependent  Other

Subscriber's Name: \_\_\_\_\_ Subscriber's SSN: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

## ACCIDENT/

### INJURY

Is your visit today related to an accident?  NO  YES

If Yes, What type?  Work Related  Auto Accident  Other \_\_\_\_\_

Date? \_\_\_\_\_

## FRIEND OR RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Patient's or Authorized Individual's Signature

Date

### Office Use

Rec'd by \_\_\_\_\_ Date \_\_\_\_\_ Update by \_\_\_\_\_ Date \_\_\_\_\_