Patient Registration

First Name: ____________ Last Name: ____________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ____________

Responsible Party *(if someone other than the patient)*

First Name: ____________ Last Name: ____________ Middle Initial: ____

Address: ____________ Address 2: ____________

City: ____________ State /Zip: ____________ Pager: ____________

Cell Phone: ____________ Work Phone: ____________ Ext: ______ Home Phone: ____________

Birth Date: ____________ SSN: ____________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ____________ Address 2: ____________

City: ____________ State /Zip: ____________ Pager: ____________

Cell Phone: ____________ Work Phone: ____________ Ext: ______ Home Phone: ____________

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

Birth Date: ____________ SSN: ____________

Email: ____________ ☐ I would like to receive correspondences via e-mail

Primary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: ____________ Insured Birth Date: ____________

Employer: ____________ Member ID: ____________

Insurance Company: ____________

Address: ____________ Address 2: ____________

City: ____________ State /Zip: ____________

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: ____________ Insured Birth Date: ____________

Employer: ____________ Member ID: ____________

Insurance Company: ____________

Address: ____________ Address 2: ____________

City: ____________ State /Zip: ____________