# PATIENT REGISTRATION INFORMATION

For Office Personnel Only

CHART#

***(WE FILE INSURANCE AS A COURTESY)***

*****NOTE: We are not providers for all insurance companies.*****

***PLEASE CHECK TO SEE IF WE ACCEPT YOUR INSURANCE BEFORE SIGNING BELOW.***

**ALL PAYMENTS ARE DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN PREVIOUSLY MADE.**
**WE COLLECT AN ESTIMATE OF WHAT YOU OWE. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT COVERED BY AN INSURANCE OR THIRD PARTY.**

DATE ______________________ HOME PHONE ☐ ( ) ______________

NAME ______________________ CELL PHONE ☐ ( ) ______________

ADDRESS ______________________ WORK PHONE ☐ ( ) ______________

CITY/STATE/ZIP ______________________ EMAIL ☐ ______________

**CHECK PREFERRED METHOD OF CONTACT**

SSN ______________________

SEX __________ BIRTHDATE __________ CIVIL STATUS

DRIVER'S LICENSE NUMBER ______________ ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

EMPLOYER ______________________

NAME OF PERSON LEGALLY RESPONSIBLE (IF MINOR) ______________________

**IN CASE OF EMERGENCY CONTACT PATIENT'S (☐SPOUSE ☐PARENT ☐OTHER)**

NAME ______________________ RELATIONSHIP ______________

RELATIVE'S ADDRESS
(HOUSE NO., STREET, APT. NO., CITY, STATE, ZIP) ______________________

NAME (FIRST) __________ (MIDDLE) __________ (LAST) __________

DATE OF BIRTH __________ EMPLOYER ______________________

HOME PHONE ( ) __________ WORK ( ) __________ CELL ( ) __________

**RESPONSIBLE PARTY** ☐PATIENT ☐EMERGENCY CONTACT **(CHECK BOX IF SAME AS PATIENT OR EMERGENCY CONTACT LISTED ABOVE)**

NAME ______________________ SSN ______________

ADDRESS ______________________ BIRTHDATE ______________

CITY/STATE/ZIP ______________________ EMPLOYER ______________

PHONE # WORK ( ) __________ HOME ( ) __________ CELL ( ) __________

**INSURANCE INFORMATION**

INSURANCE CO. ______________________ POLICY # ______________

INSURED'S NAME ______________________ SSN __________ SEX __________

INSURED'S DOB ______________________ PT'S RELATIONSHIP TO INS. ______________

INSURED'S ADDRESS (IF DIFFERENT) ______________________

SECONDARY INSURANCE ______________________ POLICY # ______________

INSURED'S NAME ______________________ SSN __________ DOB __________

PT'S RELATIONSHIP TO INSURED ______________________ INSURED'S ADDRESS ______________