PATIENT REGISTRATION

ID: _______________ Chart ID: __________________
First Name: ___________________________ Last Name: ____
Patient is: ☐ Policy Holder
☐ Responsible Party

RESPONSIBLE PARTY (if someone other than the patient)

First Name: ____
Last Name: ____
Address: ____
____
City: _____________________________________ State: ______ Zip: _____________
e-Mail Address: ____

Birth Date: _____________________________
Soc. Sec.: ______________________________
Drivers Lic.: ____________________________
Pager: _________________________________
Home Phone: ___________________________
Work Phone: ___________________ Ext:____
Cellular: _______________________________

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

PATIENT INFORMATION

Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Address: ____
____
City: _____________________________________ State: ______ Zip: _____________
e-Mail Address: ____
☐ I would like to receive correspondences via e-mail

Birth Date: ____________________ Age:____
Soc. Sec.: ______________________________
Drivers Lic.: ____________________________
Pager: _________________________________
Home Phone: ___________________________
Work Phone: ___________________ Ext:____
Cellular: _______________________________

Employer Status: ☐ Full Time ☐ Part Time ☐ Retired
Student Status: ☐ Full Time ☐ Part Time

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Group #: ____ Policy #: _______________________
Insured Soc. Sec.: ___________________________________ Insured Birth Date: ________________
Employer: ____ Ins. Company ______________________________________
Address: ____ Address: ____
City/State/Zip ____________________________________ City/State/Zip _____________________________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Group #: ____ Policy #: _______________________
Insured Soc. Sec.: ___________________________________ Insured Birth Date: ________________
Employer: ____ Ins. Company ______________________________________
Address: ____ Address: ____
City/State/Zip ____________________________________ City/State/Zip _____________________________________