Please complete the following confidential information

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOUR CHILD — START HERE

Please Print

CHILD'S NAME _____ (FIRST / M.I. / LAST) PREFERS TO BE CALLED _____

ADDRESS _____ (STREET / CITY / STATE / ZIP) HOME PHONE _____

DATE OF BIRTH _____ AGE _____ ☐ MALE ☐ FEMALE PARENT/GUARDIAN _____

IF THIS APPOINTMENT IS FOR YOU — START HERE

NAME _____ (FIRST / M.I. / LAST) PREFERS TO BE CALLED _____

ADDRESS _____ (STREET) HOME PHONE _____ OK TO LEAVE MESSAGE ☐ YES ☐ NO

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ ☐ MALE ☐ FEMALE / ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

SS# _____ - _____ - _____ (LAST 4 DIGITS REQUIRED) OCCUPATION _____ EMPLOYER'S NAME _____

WORK ADDRESS _____ (STREET / CITY / STATE / ZIP) WORK PHONE _____ OK TO CALL WORK ☐ YES ☐ NO

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR A RELATIVE A PATIENT AT OUR OFFICE? _____

NAME _____ RELATIONSHIP _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL DOCTOR _____ PHONE _____

NAME OF PREFERRED PHARMACY _____ LOCATION _____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME _____ RELATIONSHIP _____ WORK# _____ HOME# _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ☐ SAME AS PATIENT

NAME _____ (FIRST / M.I. / LAST) RELATIONSHIP _____ SS# _____ - _____ - _____

ADDRESS _____ (STREET / CITY / STATE / ZIP) HOME PHONE _____

SPOUSE'S NAME _____ (FIRST / M.I. / LAST) SPOUSE'S DATE OF BIRTH _____

SPOUSE'S EMPLOYER _____ SPOUSE'S OCCUPATION _____

SPOUSE'S WORK ADDRESS _____ (STREET / CITY / STATE / ZIP) WORK PHONE _____ OK TO CALL WORK ☐ YES ☐ NO

MEDICAL INSURANCE

INSURANCE COVERAGE ☐ YES ☐ NO

INSURANCE COMPANY

NAME _____

GROUP/PROGRAM NO. _____

SUBSCRIBER'S

NAME _____

DATE OF BIRTH _____

SS# _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

SECONDARY COVERAGE ☐ YES ☐ NO

INSURANCE COMPANY

NAME _____

GROUP/PROGRAM NO. _____

SUBSCRIBER'S

NAME _____

DATE OF BIRTH _____

SS# _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

CONFIDENTIALITY

NAME(S) OF PERSON(S) WHO MAY RECEIVE MEDICAL INFORMATION _____

Please turn over and sign