

# REGISTRATION INFORMATION

please print

Date: \_\_\_\_\_ Acct # \_\_\_\_\_

Patient Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

                    Last                      First                      Initial

Maiden Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Email Address: \_\_\_\_\_ May we use email to contact you?  Yes  No

**May we leave messages/results for you on your voice mail/answering machine/email?** Yes No (circle one)

Date of Birth: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Work No.: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_ Relationship: \_\_\_\_\_

**\* In emergency notify: (person not living with you)** \_\_\_\_\_

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

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

Pharmacy/Location: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_

Do you have Advanced Directives/Living will?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

## **PRIMARY INSURANCE**

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber No. or ID No.: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Subscriber Employed By: \_\_\_\_\_ Address: \_\_\_\_\_

## **SECONDARY INSURANCE**

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber No. or ID No.: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Subscriber Employed By: \_\_\_\_\_ Address: \_\_\_\_\_

**Who may we thank for referring you?** \_\_\_\_\_

(\*\*if patient is a child, please complete both sides of form\*\*)

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**FATHER'S INFORMATION/LEGAL GUARDIAN**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name

First Name

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

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

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Employer: \_\_\_\_\_

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

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

**MOTHER'S INFORMATION/LEGAL GUARDIAN**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name

First Name

(Maiden)

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

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

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Employer: \_\_\_\_\_

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

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

Signature of Person Completing Form: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_