# PATIENT REGISTRATION

First Name:____________________ Last Name:___________________ Middle Initial: _________

Preferred Name: ________________

Address: ________________________________________________________________________________

City, State, Zip: _______________________________________________________________________

Home Phone:________________Work Phone:________________Cell Phone:________________________

Birth date:_________Social Security #:________________ ☐ Single ☐ Married ☐ Divorced ☐ Widow

How did you hear about our office? ___________________________________________________________

E-mail: ________________________________________ ☐ I would like to receive email correspondences

Patient is: □ Responsible Party □ Policy Holder

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

First Name:__________________________Last Name:____________________ Middle Initial:_____

Address: _____________________________________________________________________

City, State, Zip: _______________________________________________________________________

Home Phone:___________________Work Phone:__________________________Cell Phone:_________

Birth date:_____________ Social Security #:_ _______________________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

**Primary Insurance Information:**

Name of Insured:________________ _ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: __________________ _ Group ID:_____________________________________

Insured Social Security #:__________ _ Insured Birth date: ______________________________

Employer:______________________ _ Insurance Company: ____________________________

Address:_______________________ _ Address: ________________________________________

Address 2: _____________________ _ Address 2: ______________________________________

City, State, Zip:_________________ _ City, State, Zip:___________________________________

**Secondary Insurance Information:**

Name of Insured:________________ _ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: __________________ _ Group ID:_____________________________________

Insured Social Security #:__________ _ Insured Birth date: ______________________________

Employer:______________________ _ Insurance Company: ____________________________

Address:_______________________ _ Address: ________________________________________

Address 2: _____________________ _ Address 2: ______________________________________

City, State, Zip:_________________ _ City, State, Zip:___________________________________