PATIENT REGISTRATION AND INSURANCE INFORMATION

(PLEASE PRINT)

Date: _______________

Patient:

___

First Name **Initial** **Last Name** **Preferred Name**

Patient Street Address ____ **City** ____________ **State/Zip** _____________

Patient Home Phone: ___________________ **Patient Work** ___________________ **Cell Phone:** _________________

Patient Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced (Child) Weight: ________

Patient Birth Date: ___________________ **Patient Social Security #:** ______________________________________

Please establish your online account to allow easy communication between you and our office. We confirm appointments by text, e-mail and phone to provide you plenty of time to let us know if you need your appointments changed. Thank you

Patient E-mail: ____

Who is responsible for this account? ____

Are they a Patient? ☐ Y ☐ N **Relationship to Patient?** ____

Primary Insurance Information

Name of Insured: _______________________ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID#: _________________ **Insured Soc. Sec:** ___________________ **Insured Birth Date:** ____________

Employer: __________________________________ **Insurance Company:** _______________________________

Address: __________________________________ **Address:** _____________________________________

City, State, Zip: ______________________________ **City, State, Zip:** ________________________________

Phone Number: _____________________________ **Group Number:** _________________________

Phone Number: _________________________

Secondary Insurance Information

Name of Insured: _______________________ **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID#: __________________ **Insured Soc. Sec:** ___________________ **Insured Birth Date:** ____________

Employer: __________________________________ **Insurance Company:** _______________________________

Address: __________________________________ **Address:** _____________________________________

City, State, Zip: ______________________________ **City, State, Zip:** ________________________________

Phone Number: _____________________________ **Group Number:** _________________________

Phone Number: _________________________

In case of emergency, who should be notified? ___________________________ **Phone:** _______________

Whom may we thank for referring you? ____