# PATIENT REGISTRATION (CONFIDENTIAL)

Name_____ Birthdate_____
First MI Last

Address_____ City_____State___ Zip_____

E-Mail_____ Cell Phone_____ Home Phone_____

**SSN#**_____

Circle Appropriate Status: Minor Single Married Divorced Widowed Separated

Patient's or Parent's/Guardian's Employer_____Work Phone._____

Spouse or Parent's/Guardian's Name_____

Employer_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency_____Phone_____

## RESPONSIBLE PARTY (If different from insurance subscriber)

Name of person responsible for this account_____Relationship to patient_____

Address_____ Home Phone_____

Driver's License#_____Birthdate _____

Employer_____Work Phone_____

Is this person a patient in our office? YES NO

## INSURANCE INFORMATION

Name of subscriber:_____Relationship to patient_____

Birthdate of subscriber_____SSN#_____

Name of Employer _____

Insurance Co._____Tel.#_____Grp#_____Policy/I.D.#_____

**DO YOU HAVE ADDITIONAL INSURANCE?** ☐**YES** ☐**NO** **If yes, complete the following:**

Name of insured_____Relationship to patient_____

Birthdate_____SSN#_____

Employer_____ Work Phone_____

As a courtesy we will submit insurance once on your behalf. Although reasonable attempts are made to determine your coverage prior to service, it is your responsibility to understand your insurance coverage, copays, and deductibles. Your policy may not cover emergency evaluations, temporary treatments or other common necessary procedures/

**X_____ Date_____**

Signature of Patient or Parent/Guardian if Minor