Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ___

Prefers to be called by: _____

Address: _____ Address Line 2: _____

City, State, Zip: _____

Home Ph. _____ Mobile Ph. _____ Work Ph. _____

Email: _____

Birth Date: _____ SSN: _____ Occupation: _____

Gender: M FMarital Status: _____ Referred by: _____

Best Contact Method: _____ Phone _____ Text _____Email

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ___

Prefers to be called by: _____

Address: _____ Address Line 2: _____

City, State, Zip: _____

Home Ph. _____ Mobile Ph. _____ Work Ph. _____

Email: _____

Birth Date: _____ SSN: _____ Occupation: _____

Relationship to Patient: _____

Person to Contact for Emergency

Name: _____

Home Ph. _____ Mobile Ph. _____ Work Ph. _____

Address: _____ Address Line 2: _____

City, State, Zip: _____

Primary Insurance Information

Relationship to the Insured (Mark One): Self _____ Spouse ____ Child ____ Other _____

Name of Insured: _____ Employer: _____

Group Number :_____

Member ID :_____

Insurance Company :_____

Address of Company :_____

Secondary Insurance Information

Relationship to the Insured (Mark One): Self _____ Spouse ____ Child ____ Other _____

Name of Insured: _____ Employer: _____

Group Number : _____

Member ID : _____

Insurance Company : _____

Address of Company : _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patients Signature :_____

Date: _____