

Date _____

Patient Registration

Patient Name _____ Date of Birth ____/____/____ Age _____

Street Address _____ SS# _____ Male/Female

City _____ State _____ Zip _____ Marital Status S M Sep D W

Tel# Home() _____ Tel# Work() _____ Cell#() _____

Spouse _____ Address if different than above _____

Referred by Dr. _____ Tel# () _____ Fax# () _____

Primary Care Physician _____ City _____ Tel# () _____

Responsible Party _____ Address if different than above _____

Emergency Contact _____ Tel# () _____ Relationship _____

Employer Information

Employer Name _____ Occupation _____ Tel#() _____

Employer Address _____ City _____ State _____ Zip _____

Insured Person If Not Patient

Name _____ Relationship to Patient _____ Tel#() _____

Address if different than above _____ SS# _____

Date of Birth ____/____/____ Employer _____ Tel#() _____

Insurance

Primary Insurance Co. _____ Co-Pay\$ _____

ID# _____ Group# _____ Tel#() _____

Secondary Insurance Co. _____

ID# _____ Group# _____ Tel#() _____

General Medical Information

Reason for visit today _____

Allergies to Medication _____

Present Medications _____

Other Physicians treating you _____

Do we have your permission to?

Leave a message on your answering machine at home? _____ YES _____ NO

Leave a message at your place of employment? _____ YES _____ NO

Discuss your medical condition with any member of your household? _____ YES _____ NO

If yes, whom _____ Tel#() _____

Relationship _____

Patient or Responsible Party Signature _____ Date _____