



**Patient Registration Form**

**PATIENT INFORMATION**

(Please Print)

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Also Known As Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Phone Numbers Work \_\_\_\_\_  Day  Evening Home \_\_\_\_\_  Day  Evening  
Cellular \_\_\_\_\_ Pager \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP (+4) \_\_\_\_\_  
Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Emergency Contact Relationship to Patient \_\_\_\_\_  
Referring Provider Name \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone Numbers Work \_\_\_\_\_  Day  Evening Home \_\_\_\_\_  Day  Evening  
Address \_\_\_\_\_  
City, State, ZIP (+4) \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_  
Insured Employer Name \_\_\_\_\_  
Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male  
Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

(provide your insurance card to the front desk at check-in)

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_  
Insured Employer Name \_\_\_\_\_  
Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male  
Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.  
) \*\*\*\*I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPPA privacy policies and understand that any questions or complaints may be addressed to the Privacy Officer without penalty (Office Manager).

Patient (or Responsible Party) Signature \_\_\_\_\_ Date \_\_\_\_\_