

Patient Registration Form

Date: _____

Patient: (last,first,MI): _____ Social Security # _____
 College: _____ Graduation Date: _____ Date of Birth: _____
 Address: _____ Gender: M F
 City: _____ State: _____ Zip Code: _____ Marital Status: S M D W
 Employer: _____ Telephone Number: _____
 Work Telephone: _____ Cellular: _____
 Address: _____ Ok to leave voice mail message? Y _____ N _____
 City: _____ State: _____ Zip Code: _____ Driver License #: _____
 Ethnicity: Caucasian; African American; Hispanic; Asian/Oriental; Native American; C Driver License State: _____
 E-Mail Address: _____ Ok to e-mail results? Y _____ N _____
 Do you have a current living will? Y _____ N _____ If not, would you like to complete one? Y _____ N _____

FINANCIAL INFORMATION

Responsible Party (full name): _____ Social Security # _____
 Relationship to Patient: ___ Self ___ Parent ___ Legal Guardian ___ Power of Attorney ___ Spouse Gender: M F
 Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number: _____ Marital Status: S M D W
 Work Telephone: _____

PRIMARY INSURANCE INFORMATION

(Patient should use Insurance ID Card to complete the following)

Insurance Company: _____ Insurance Telephone Number: _____
 Policy Holder Name: _____ Policy Holder SS # _____
 Relationship to Patient: ___ Self ___ Parent ___ Legal Guardian ___ Power of Attorney
 Policy Number: _____ Group Number: _____
 Address to Mail Claims: (organization) _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Insurance Telephone Number: _____
 Policy Holder Name: _____ Policy Holder SS # _____
 Relationship to Patient: ___ Self ___ Parent ___ Legal Guardian ___ Power of Attorney
 Policy Number: _____ Group Number: _____
 Address to Mail Claims: (organization) _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

I attest that the information above is correct and that the insurance information noted is the only coverage I have at the current time. Unless recorded above, I have no secondary insurance coverage.

It is important that all information on this form be supplied to us in order to file your insurance.