Patient Registration Form

CLICK HERE TO SEND E-MAIL

For Office Use Only	ID:	Chart ID:	Date:

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

Preferred Name: _____

Patient is ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2 : _____

City: _____ State: _____ Zip: _____

Home Phone # : _____ Work Phone #: _____ Ext: _____ Cell Phone #: _____

Date of Birth: _____ Social Security #: _____ Drivers License: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2 : _____

City: _____ State/Zip: _____ Pager: _____

Home Phone # : _____ Work Phone #: _____ Ext: _____ Cell Phone #: _____

Sex ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ Social Security #: _____ Drivers License: _____

E-mail: _____

☐ I understand that I will receive appointment information via e-mail unless other arrangements are made.

☐ I authorize messages left on: ☐ Cell ☐ Home ☐ Work

Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Employer ID: _____ Pref Pharmacy: _____

Carrier ID: Pref Hyg:

Section 3

Cell Phone: _____

☐ I would like to receive communication via cell.

☐ I authorize text messages on Cell

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security /Policy #: _____ Insured Date of Birth: _____

Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address 2 : _____	Address 2 : _____
City, State, Zip: _____	City, State, Zip: _____

For Office Use Only- Rem Benefits: Rem Deductible:

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security /Policy #: _____ Insured Date of Birth: _____

Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address 2 : _____	Address 2 : _____
City, State, Zip: _____	City, State, Zip: _____

For Office Use Only- Rem Benefits: Rem Deductible:

Contact in Case of Emergency: _____ Relationship: _____ Phone: _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

How Did You Find Us? Referred By Whom?