PATIENT REGISTRATION
PLEASE FILL OUT FORM COMPLETELY

Patient Information:

Patient: ______________________________ Date of Birth: ____________________

Marital Status: ________ Age:________ Race: ________ Sex: __________ Allergies: ____________________

Address: ______________________________ City/State/Zip: ______________________________

Home Phone: (_____) ____________________ Alternate Phone: (____) ____________________

Social Security Number:____________________ Employer: ______________________________

Referred By: ______________________________

Method of Contact: Text: __________________ Email: ______________________________

Emergency Contact Information:

Name: ____ Relationship: ________________________

Phone Number: __________________________________

Guarantor Information:

Name: ____ Relationship: ________________________
Date of Birth: ____________________________ Social Security Number: ________________________
Address: ____
Employer: _________________________ Phone Number: ______________________________

Primary Insurance: __________________________ Policy # ____________________________

Insured: __________________________ Relationship: ________________________ DOB: __________

Policy Holder SSN: ________________________ Employer: ____________________________

Group Name: Group Number:

Secondary Insurance: __________________________ Policy # ____________________________

Insured: __________________________ Relationship: ________________________ DOB: __________

Policy Holder SSN: ________________________ Employer: ____________________________

Group Name: Group Number:

CLINICAL USE ONLY:

Medical Record #: __________________ Account #: ________________________

Admit Date: _____________ Admit Time:________________ Admit By: ____________________

Attending Therapist: __________________________ Admitting Diagnosis: ______________________

Previous Admit Date: ______________________