PATIENT REGISTRATION

Patient's Legal Name:_____ Preferred Name: _____

Birthdate:_____/_____/_____ Age:_____ Sex: M / F Phone number:_____

Address: _____ City, State, Zip: _____

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME: _____ Marital Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home phone: _(_____)_____ Cell/Work #: _(_____)_____

Social Security: _____-_____-_____ Drivers License #: _____ Birthdate: ___/___/__

Email address: _____

MOTHER'S NAME: _____ Marital Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home phone: _(____)_____ Cell/Work #: _(_____)_____

Social Security: _____-_____-_____ Drivers License #: _____ Birthdate: ___/___/___

Email address: _____

Who is the Custodial Parent? _____

May patient information be released to the non-custodial parent? Yes / No

EMERGENCY INFORMATION

Name:_____ Relationship to patient: _____

Home Phone:_(___)_____ Cell/Work #: _(___)_____

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ Insured Soc. Sec: _____ Insured ID: _____

Insured DOB_____ Employer: _____ Ins. Co.:_____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Insured Soc. Sec: _____Insured ID:_____

Insured DOB_____ Employer:_____ Ins. Co.:_____