Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Relation to Patient _____ Guarantor Email _____

Patient Information

Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ Email _____
Date of Birth _____ Sex _____ Marital Status _____
Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native
☐ Native Hawaiian, Other Pacific Islander ☐ Unknown ☐ Declined
Ethnicity: ☐ Hispanic or Latino ☐ Not-Hispanic or Latino ☐ Unknown ☐ Declined
Primary Language _____
Social Security Number _____
(If a minor): Mother's Name _____ Home Phone # _____
Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____
Relationship to Patient _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Name _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Name _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Referred by _____

Signature _____ Date _____ Time _____

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