

## REGISTRATION FORM

Legal Name:		Preferred Name:		Today's Date:		Date of Birth:	
Legal Sex/Gender:	Preferred Sex/Gender:	Race:	Age:	Primary Care Physician (PCP):		PCP Telephone #:	
Address:			City:		State:	Zip:	
Telephone #:		Email Address:		I would like a reminder of my appointments (check all that apply):			
Okay to leave a message with business name?    Y   N Okay to text?    Y   N		Okay to email identifying business name?    Y   N		<input type="checkbox"/> Telephone <input type="checkbox"/> Text Message <input type="checkbox"/> Email <input type="checkbox"/> None			
Please briefly describe the problem(s) for which you are seeking services:							

### EMERGENCY CONTACT

Name:	Telephone #:	Relationship:
-------	--------------	---------------

### INSURANCE INFORMATION

#### Primary Insurance

Insurance Carrier:	Member ID #:	Group ID #:	Name of Primary Insured:	
Relationship to Primary Insured:	Date of Birth of Primary Insured:		Copayment:	Deductible:
Primary Insured Address:		City:	State:	Zip:

#### Secondary Insurance

Insurance Carrier:	Member ID #:	Group ID #:	Name of Primary Insured:	
Relationship to Primary Insured:	Date of Birth of Primary Insured:		Copayment:	Deductible:
Primary Insured Address:		City:	State:	Zip:

If you have insurance, please provide us with a copy of your insurance card prior to your initial evaluation.

### FOR CHILDREN (under 18 years of age)

Parent/Legal Guardian:	Type of Custody: _____ N/A    _____ Joint    _____ Sole    _____ Physical    _____ Legal _____ No Custody    _____ Other _____
------------------------	--

If more than one legal guardian/parent, please provide contact information for the other parent/guardian.

Parent/Legal Guardian:	Type of Custody: _____ N/A    _____ Joint    _____ Sole    _____ Physical    _____ Legal _____ No Custody    _____ Other _____			
Address:		City:	State:	Zip:

### OTHER INFORMATION

Food/Drug Allergies:	
Employer:	Employer Telephone #: