

Registration Form

Who referred you to us? _____ Primary care Doctor: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Nick Name _____ Middle Initial _____
 Street Address _____
 City _____ State _____ Zip Code _____ County _____
 Date of Birth ____ / ____ / ____ Age _____ SSN ____ / ____ / ____ Drivers License Number _____
 Home Phone (____) _____ Cell Phone _____ Fax _____
 Your other doctors _____ Email _____

SPOUSE INFORMATION

Last Name _____ First Name _____ Middle Initial _____
 Social Security Number _____ Spouse's Date of Birth _____
 Employer _____ Work Phone _____

INSURANCE INFORMATION

[Please Have Insurance Card(s) Ready To Be Copied]

Do you have insurance? Yes No If not, how do you intend to pay? Cash Check Visa/MC

HEALTH INSURANCE INFORMATION

PRIMARY Insurance Company: _____ Effective Date: _____
 Policy Number: _____ Group Number: _____
 Insured Name: _____ Insured Birthdate: _____ Insured SS#: _____
 Patient's Relationship to Insured: _____

SECONDARY Insurance Company: _____ Effective Date: _____
 Policy Number: _____ Group Number: _____
 Insured Name: _____ Insured Birthdate: _____ Insured SS#: _____
 Patient's Relationship to Insured: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

Have you filed a First Report of injury with your employer? Yes No
 Insurance Company Name: _____
 Address: _____
 Phone: (____) _____
 Claim Number: _____ Contact Person or Nurse Case Manager (if applicable): _____

PATIENT'S EMPLOYER INFORMATION

Employer's Name: _____ Employer's Phone Number: (____) _____
 Employer's Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Occupation: _____

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NOTIFY IN EMERGENCY

Nearest friend/relative not living with you: _____ Relationship _____

Phone Number (____)-_____

**IMPORTANT: Please verify that all information provided above is complete and correct.
Failure to do so may result in balance billing to the patient/guarantor.**

Minor Patient

Appointment Date _____

Last Name _____ First Name _____ Nick Name _____ Middle Initial _____

GUARANTOR INFORMATION

MOTHER'S INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip Code _____ County _____

Date of Birth ____/____/____ Age _____ SSN ____/____/____ Drivers License Number _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Sex Male Female Marital Status S M D W Spouse's Name _____

Employer's Name _____ Employer's Phone _____

Employer's Street Address _____

Employer City _____ State _____ Zip Code _____

FATHER'S INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip Code _____ County _____

Date of Birth ____/____/____ Age _____ SSN ____/____/____ Drivers License Number _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Sex Male Female Marital Status S M D W Spouse's Name _____

Employer's Name _____ Employer's Phone _____

Employer's Street Address _____

Employer City _____ State _____ Zip Code _____

PERSONAL GUARANTY

To induce Provider to extend credit terms to Patient, the undersigned guarantees payment of all charges by Provider to Patient, including interest and fees, incurred at any time prior to the receipt by Provider of written notice of cancellation of the guaranty as outlined in the authorization form.

Date: _____ Guarantor: _____

IN THE EVENT THE PARENT/GUARDIAN IS NOT PRESENT

I, _____, the undersigned parent/guardian or _____, do hereby grant permission for _____ to authorize medical treatment for my above named child/ward, in the event that I cannot be present during the treatment of the child.

Signed _____ Date _____

