

# Patient Registration Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (MI)

Street Address: \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital status \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
(Name) (Phone)

Primary Care Physician: \_\_\_\_\_  
(Name) (Phone)

Please provide us with the names of other doctors that are sharing in your care:

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Name: \_\_\_\_\_ Location: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Location \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Emergency Phone # (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

\*\*\*\*\* **Employer Information** \*\*\*\*\*

**Do you work?** (circle one) YES NO

**Does your spouse work?** (circle one) YES NO

**Your Occupation:** \_\_\_\_\_

**Your Employer:** \_\_\_\_\_

\*\*\*\*\* **Insurance Information** \*\*\*\*\*

**Name of person responsible for bills:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone#** (\_\_\_\_) \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Co-Pay:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Subscribers Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Subscribers Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**IF YOUR PRIMARY OR SECONDARY INSURANCE IS THROUGH YOUR SPOUSE'S EMPLOYMENT OR YOUR PARENT'S EMPLOYMENT, PLEASE PROVIDE US WITH THEIR:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_