REGISTRATION & TREATMENT

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Date: _____ Home Phone (_____) _____

Cell Phone (_____) _____

PATIENT INFORMATION

Name: _____ SS/HIC/Patient ID #: _____
Last Name First Name Middle Initial

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone (_____) _____

Whom may we thank for referring you?: _____

In case of emergency who should be notified?: _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last Name First Name Middle Initial

Relation to Patient: _____ Birthdate: _____ ID#/Soc. Sec. #: _____

Address (If different from patient's): _____ Phone (_____) _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone (_____) _____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____ Relation to Patient: _____ Birthdate: _____

Address (If different from patient's): _____ Phone (_____) _____

City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Business Phone (_____) _____

Insurance Company: _____ Soc. Sec. #: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____