

Welcome!

REGISTRATION FORM

Section I:	Patient Information	Date _____
Name: _____	I Prefer to be called: _____	
Address: _____	City: _____	State: _____ Zip _____
Phone (____) _____	Work Phone (____) _____	Cell Phone (____) _____
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____	Social Security Number: _____	
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____		City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT
Spouse or Parent's Name: _____	Employer _____	Work Phone _____
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____		Phone _____
Email Address _____		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____	Relationship to Patient: _____
Address: _____	
City: _____	State: _____ Zip: _____ Phone: (____) _____
Employer _____	Work Phone (____) _____ SSN# _____

Section III	Insurance Information	
Name of Insured _____	DOB _____	Relationship to Patient _____
SSN#: _____	Name of Employer: _____	Work Phone: (____) _____
Address of Employer: _____		City _____ State: _____ Zip _____
Insurance Company _____	Group # _____	ID# _____
Ins Co Address: _____		Ins Co. Phone: _____