PATIENT REGISTRATION FORM

Patient

Name: _____ Today's Date:_____

Address:_____ City:_____

Postal Code:_____ Date of Birth:_____

Home Phone Number:_____Email:_____

Cell Phone:_____ Preferred Contact Method(circle): Phone / Cell / Email

How did you hear about us?:_____

Person Responsible(if patient under 18 years old):_____

please print

Address(if different from above):_____

Phone Number:_____ Date of Birth:_____

"Person Responsible" is assumed to be a parent or legal guardian who is accepting personal and financial responsibility for the patient named above.

Signature of Person Responsible:_____ Date:_____

Insurance Information

Primary Insurance

Policy Holder Name:_____ Date of Birth:_____

Relationship to Patient:_____

Employer:_____ Insurance Company:_____

Policy/Plan Number:_____ Certificate/ID Number:_____

Secondary Insurance

Policy Holder Name:_____Date of Birth:_____

Relationship to Patient:_____

Employer:_____ Insurance Company:_____

Policy/Plan Number:_____Certificate/ID Number:_____

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Signature of Patient:_____ Date signed:_____

If under 18 years old, please have Person Responsible sign.