



### Patient Registration Form

**Name:**

\_\_\_\_\_  Jr.  Sr.  
First Middle Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  F  M Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
Street # Street Name  
\_\_\_\_\_  
City State Zip

Email Address: \_\_\_\_\_

Day Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Evening Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

**Insurance Information:** Do you have insurance?  Yes  No

Primary Insurance Carrier: \_\_\_\_\_

Name of Insured (Primary): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Insured (Primary): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**May we leave personal medical information on your Voicemail at home?**  Yes  No

**May we e-mail personal medical information to you?**  Yes  No

E-mail address: \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

Yes  No If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_)\_\_\_\_ Phone # (evening): (\_\_\_\_)\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_)\_\_\_\_ Phone # (evening): (\_\_\_\_)\_\_\_\_

**Emergency Contact Information:**

In case of Emergency, whom should we notify? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_

**Please present your insurance card(s) and your photo identification to the receptionist who will make a copy for your file and return them to you promptly.**

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. ***PAYMENT IS EXPECTED FROM YOU, FOR "YOUR PORTION OF THE CHARGES," AT THE TIME OF SERVICE.*** For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND BANK DEBIT CARDS. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any) and herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Employment Information:

Employer Name: \_\_\_\_\_

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

Street # Street Name

City State Zip

Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_

Preferred Pharmacy information:

Name of Pharmacy: \_\_\_\_\_

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

Street # Street Name

City State Zip

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_