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PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Gender Male Female
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Email: _____ Preferred form of contact: Home Cell Work
Employer: _____ Marital Status: _____ SS# _____

Parent/Guardian (For Minors)

Name: _____ DOB: ____/____/____ Male Female
Relationship to the patient: Mother Father Stepmother Stepfather Other: _____
SS# _____ Marital Status: _____ Email: _____
Home _____ Cell phone: _____ Work phone: _____
Address: Same as patient. If not please list address here:
Street Address: _____ City: _____ State: _____ Zip: _____

Other Parent/Guardian (For Minors)

Name: _____ DOB: ____/____/____ Male Female
Relationship to the patient: Mother Father Stepmother Stepfather Other: _____
SS# _____ Marital Status: _____ Email: _____
Home _____ Cell phone: _____ Work phone: _____
Address: Same as patient. If not please list address here:
Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care

Physician Name: _____ Location: _____ Date Last Seen: _____

Insurance

Primary Insurance: _____ Primary Policyholder: _____
Policyholder Date of Birth: _____ Relationship to Policyholder: _____
Policy ID#: _____ Group #: _____

Secondary Insurance

Secondary Insurance: _____ Secondary Policyholder: _____
Policyholder Date of Birth: _____ Relationship to Policyholder: _____
Policy ID#: _____ Group #: _____

Privacy Information Preferences

- May we send mail to the address on file? Yes No
- May we call the phone numbers on file? Yes No
- May we leave a voicemail on answering machines? Yes No
- Persons Authorized to receive medical information and/or messages:

Signature: _____ Date: _____