



## REGISTRATION FORM

Date of Appointment \_\_\_\_\_

### Patient Demographics

Patient name \_\_\_\_\_ SSN \_\_\_\_\_

Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Aliases \_\_\_\_\_

Permanent address \_\_\_\_\_ Home phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work phone \_\_\_\_\_

E-mail \_\_\_\_\_ Cell phone \_\_\_\_\_

Language \_\_\_\_\_ Interpreter needed? \_\_\_\_\_

Marital status \_\_\_\_\_ Race \_\_\_\_\_

### Primary Care Provider (PCP) Information

New PCP \_\_\_\_\_ Effective date \_\_\_\_\_

### Employment

Employer \_\_\_\_\_ Employment status \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

Country \_\_\_\_\_

## Emergency Contact Information

DO NOT SCAN

### Contact 1:

Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ Work phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell phone \_\_\_\_\_  
Relationship \_\_\_\_\_ Legal guardian? \_\_\_\_\_

### Contact 2:

Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ Work phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell phone \_\_\_\_\_  
Relationship \_\_\_\_\_ Legal guardian? \_\_\_\_\_

## Guarantor Account Questionnaire

What type of guarantor account would you like to add to this patient?

Personal/Family  Workers Comp  Third party  Add'l type \_\_\_\_\_

Name of person responsible for final balance due on account \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to patient:  Self  Employer  Spouse  Father  Mother  Other \_\_\_\_\_

Address \_\_\_\_\_ Cell phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Legal guardian? \_\_\_\_\_

## Primary Coverage (Insurance)

Who is the subscriber (policyholder) for the coverage? \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Coverage (insurance) name \_\_\_\_\_

Coverage (insurance) phone \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

## Secondary Coverage (Insurance)

Who is the subscriber (policyholder) for the coverage? \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Coverage (insurance) name \_\_\_\_\_

Coverage (insurance) phone \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_