Patient Registration Form

Compassion, Confidence, Comfort

Date: ____________________ Patient E-Mail Address: ____________________________________

Name: ________________________________ Date of Birth: ________________ Weight: ______

Address: _________________________________ City: ___________________ Zip: ____________

Phone Number(s) Home: ________________ Work: ________________ Cell: ________________

Emergency Contact Name: ____________________ Emergency Contact Phone: ________________

Referring Physician: ________________________ Primary Physician: ________________________

Marital Status: Please Circle: **Single** **Married** **Legally Separated** **Widowed** **Divorced**

Student Status: Please Circle: **Full Time** **Part Time** **Not Applicable**

Employment Status: Please Circle: **Full Time** **Part Time** **Unemployed** **Retired** **Disabled**

Employed by: _______________________________ Occupation: _____________________________

Social Security #: _____________________________ Please Circle one: **MALE** **FEMALE**

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Primary Insurance: __________________________________

If **Responsible Person** for **PRIMARY** payment is ***different than patient*** – please fill out following:

Person Responsible for Payment: ______________________________ Date of Birth: ______________

Relation to Patient: **Spouse** **Parent** **Other** Social Security #: ____________________________

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Secondary Insurance: _________________________________

If **Responsible Person** for **SECONDARY** payment is ***different than patient*** – please fill out following:

Person Responsible for Payment: ______________________________ Date of Birth: ______________

Relation to Patient: **Spouse** **Parent** **Other** Social Security #: ____________________________