



Registration Form

(Any information the same please put in "same")

Date: _____ SS# _____ DOB: _____

Name: _____ Age: ____ Sex: ____
(Last) (First) (MI)

Address: _____

Phone: _____ Race: _____ Marital Status _____ Religion (optional) _____

Employer Information (if patient is a minor, enter responsible party information)

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone # _____ SS# _____

(Responsible party if patient is a minor)

Next of Kin/ Emergency Contact (if this person is both)

Name: _____ Relationship _____

Address: _____

Home Phone: _____ Work Phone: _____

Guarantor (insurance carrier)

Same as patient

Guarantor's SS# _____ Guarantor's DOB: _____

Name: _____ Age: ____ Sex: ____
(Last) (First) (MI)

Address: _____

Phone: _____ Race: _____ Marital Status _____

Insurance to be billed (If Workers Comp please list contact name and number)

Name: _____ Phone Number: _____

Policy Number: _____

Group Number: _____

Secondary Insurance (If auto or workers comp is being billed primary, please list health insurance)

Name: _____ Phone Number: _____

Policy Number: _____

Group Number: _____

Family Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

Patients are responsible for knowing the limits of his/her insurance. Insurance information and physician orders must be available at the time of registration. If insurance card/information is not available, the patient's account will be registered as self-pay. We are unable to provide treatment without physician orders. Thank you!