

**PATIENT REGISTRATION**  
**PLEASE PRINT**

**Patient information:**

First Name \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed  
E-mail \_\_\_\_\_ correspondence by email \_\_\_ Yes \_\_\_ No  
Student Status: \_\_\_ Full time \_\_\_ Part time where: \_\_\_\_\_  
Employment Status \_\_\_ Full time \_\_\_ Part time \_\_\_ Retire  
Employer / Address \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Were you referred to us? If so by Whom: \_\_\_\_\_

***If the responsible party is someone other than Patient – please fill out below:***

**Responsible Party:**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Soc Sec: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, and Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Parent \_\_\_ Other

***Is policyholder different than Responsible Party? If Yes, please answer following:***

Name of Insured: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Soc Sec: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Group # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

***If you have your Insurance card available, our staff will make a copy of it for our records – then not all of the information will need to be filled out:***

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Group # \_\_\_\_\_ Insurance ID # \_\_\_\_\_

**HIPPA REGISTRATION** \_\_\_\_\_