



New Patient Registration Form

Please Print

Today's Date												
PATIENT INFORMATION												
Full Legal Name (First) (Middle) (Last)								Name Normally Used (Nickname)				
Address						Apt. No.		City		State		Zip
E-mail			Home Phone			Work Phone			Cell Phone			
Social Security No.		Sex	Marital Status		Date of Birth		Driver's License No.			State Issued		
Employer Name			Employer City		Employer State	How Did You Hear About Us?						
List anyone you authorize this office to share your medical information with (name and relationship to you)												
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail								Ok to leave message on answering machine/voicemail? Yes ___ No ___				
SPOUSE'S INFORMATION												
Full Legal Name (First) (Middle) (Last)								Home Phone				
Occupation		Employer name				Work phone		Cell Phone				
INSURANCE INFORMATION												
Primary Insurance Company Name						Group No.			ID/Certificate No.			
Policy Holder's Name/Parent's Name (if patient a child)				D.O.B.		Policy Holder's Social Security No.						
Secondary Insurance Company Name						Group No.			ID/Certificate No.			
Policy Holder's Name												
EMERGENCY INFORMATION												
Person to Notify in Case of Emergency					Relationship		Home Phone		Cell Phone			
INFORMATION FOR THE PATIENT												
<p>1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.</p> <p>2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.</p>												