PATIENT INFORMATION (CONFIDENTIAL)

NAME ______ (FIRST) ______ (MI) ______ (LAST) ______ DATE ______

ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

E-MAIL ______ CELL PHONE ______ HOME PHONE ______

SS#/SIN ______ BIRTHDATE ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL ______ CITY ______ STATE/PROV. ______

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER ______ WORK PHONE ______

BUSINESS ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

SPOUSE OR PARENT'S/GUARDIAN'S NAME ______ EMPLOYER ______ WORK PHONE ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______ PHONE ______

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______ RELATIONSHIP TO PATIENT ______

ADDRESS ______ HOME PHONE ______

DRIVER'S LICENSE # ______ BIRTHDATE ______ SS#/SIN ______

EMPLOYER ______ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS#/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ UNION OR LOCAL # ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ______ SS#/SIN ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ UNION OR LOCAL # ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

INSURANCE CO. ______ TEL. # ______ GRP # ______ POLICY / I.D. # ______

INS. CO. ADDRESS ______ CITY ______ STATE/PROV. ______ ZIP/P.C. ______

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX ANNUAL BENEFIT? ______

ITEM 07-0515767/27000

X ______

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

______

PATIENT NUMBER

REGISTRATION