



## REGISTRATION FORM

### PATIENT INFORMATION:

Patient's Name (First /Middle/Last): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

(Street)

(City)

(State)

(ZIP)

Home #: (     ) \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender:    M     F

### PARENT/GUARDIAN INFORMATION:

Name (First/Middle/Last): \_\_\_\_\_

Name (First/Middle/Last): \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Home #: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_

Work #: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

### INSURANCE INFORMATION:

Please notify the office of any insurance changes at each visit that may affect your account. We will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last): \_\_\_\_\_

Subscriber (First/Middle/Last): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ Group #: \_\_\_\_\_

DOB: \_\_\_\_\_ Group #: \_\_\_\_\_

Contract/ID #: \_\_\_\_\_

Contract/ID #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Phone #: \_\_\_\_\_ Co-pay: \_\_\_\_\_

Phone #: \_\_\_\_\_ Co-pay: \_\_\_\_\_

### EMERGENCY CONTACT (Person to contact in case of an emergency)

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_

(Cell) \_\_\_\_\_

SIGNATURE OF RESPONSIBLE PARTY  Mother  Father  Guardian

X \_\_\_\_\_ Date: \_\_\_\_\_