

## New Patient Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Gender: M F

DOB: \_\_\_\_\_ SSN# \_\_\_\_\_

Occupation: \_\_\_\_\_

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

City/State/Zipcode: \_\_\_\_\_

Phone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Please **circle** preferred phone number

Is it **OK** to leave messages regarding appointments, results, etc. at this number? **Y N**

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

Is it **OK** to send messages about your health via email? **Y N**

How did you hear about the clinic? \_\_\_\_\_

Who should be contacted in case of an emergency?

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

Phone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

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

Phone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

### Patient Insurance Info

**(Please remember to bring your insurance card to your appointments)**

Name of **Primary** Insurance Company: \_\_\_\_\_

ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-Pay Amount: \$ \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Subscriber's Phone Number: \_\_\_\_\_

Subscriber's Employer Name: \_\_\_\_\_

Name of **Secondary** Insurance Company: \_\_\_\_\_

ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-Pay Amount: \$ \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Subscriber's Phone Number: \_\_\_\_\_

Subscriber's Employer Name: \_\_\_\_\_