# Patient Registration Form

| Patient Info | | | |
|---|---|---|---|
| First Name | | | |
| Last Name | | | |
| Address | | | |
| City/State/Zip | | | |
| Phone | | Alt Phone | |
| Email | | | |
| Date of Birth | | | |
| Age | | | |
| Sex | Male ☐ | Female ☐ | |
| Cell Phone | | Work Phone | |
| Social Security Number | | | |

| Patient Info | | | | |
|---|---|---|---|---|
| Marital Status | Married ☐ | Single ☐ | Divorced ☐ | Widowed ☐ |
| Employment Status | Full time ☐ | Part Time ☐ | Unemployed ☐ | |
| | Retired ☐ | Student ☐ | Other..... | |
| Emergency Contact | | Relationship to Patient | | |
| Address | | Phone Number | | |

| Insurance Information |
|---|
| Primary Insurance |
| Secondary Insurance |

# Patient Registration Form

| | | |
|---|---|---|
| Patient is Subscriber/Policy Holder | Y ☐ | N ☐ |

| INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card | |
|---|---|
| Subscriber/ Policy Holder: | Relationship to Patient: |
| Social Security Number: | |
| Address | |
| Date of Birth: | |
| His or Her Employer: | Work Phone Number: |
| **RELEASE OF INFORMATION**<br><br>**I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.** | |
| Name(s): | Relationship to Patient: |