

# Patient Registration Form

Date of Appointment \_\_\_\_\_

## Patient Information

|  |  |                    |               |                        |
|--|--|--------------------|---------------|------------------------|
| Patient's First Name   |  | Middle Name        | Last Name     |                        |
| Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Marital status<br><input type="checkbox"/> Single <input type="checkbox"/> Married | Date of Birth(Age) |               | Social Security Number |
| Patient's Address  |  | City               | State         | Zip Code               |
| Home Phone Number  |  | Mobile Phone       | Email Address |                        |

Best way to contact you:  Email  Cell  Landline  TextHow did you hear about us? (Select **ALL** Applicable )  Insurance Website  Friend  Google  Yelp  Family  Flyer  Zoc Doc  Other

## Patient Employer/School Information

|                         |            |                       |     |
|-------------------------|------------|-----------------------|-----|
| Employer/School         | Occupation | Employer/School Phone |     |
| Employer/School Address | City       | State                 | Zip |

## Emergency Contact Information

|                        |                         |                     |
|------------------------|-------------------------|---------------------|
| Emergency contact name | Emergency Contact phone | Relation to Patient |
|------------------------|-------------------------|---------------------|

## Billing and Insurance

### Subscriber I.D:

|                        |              |                               |
|------------------------|--------------|-------------------------------|
| Insurance Company Name |              |                               |
| Plan Number            | Group Number | Insured's Employe/School Name |

**Is the patient also the insurance Policy Holder?**  Yes  No

If no, please provide below details for the insurance subscriber.

|  |                     |                           |     |
|--|---------------------|---------------------------|-----|
| Subscriber's Name (As appears on insurance card or Id) | Relation to Patient | Subscriber's Phone Number |     |
| Insured's Address                                      | City                | State                     | Zip |
| Insured's Social Security Number                       | Insured's Birthday  |                           |     |

### Responsible Party (Please fill this section if Patient is a minor)

|              |       |                     |          |
|--------------|-------|---------------------|----------|
| Billing Name | Phone | Relation to patient |          |
| Address      | City  | State               | Zip Code |

\_\_\_\_\_  
Signature of Patient or Authorized Guardian\_\_\_\_\_  
Date

