PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

1.PATIENT NAME_____, _____, _____DATE OF BIRTH_____/_____/_____ SEX: M F
LAST FIRST MI

2. ADDRESS_____, _____, _____,
3. HOME PHONE: (_____)_____ WORK: (_____)_____CELL: (____)_____
4. EMAIL Address _____
5. ADHAR NUMBER_____-_____-_____ MARITAL STAUS: ___ Married __ Single ___Widowed
6. EMPLOYMENT: ___Employed ___Unemployed ___Retired ____Other EMPLOYER:_____
7. PRIMARY INSURANCE CO:_____ ID #_____ GROUP #_____
8. IF INSURANCE IS THROUGH SOMEONE OTHER THAN PATIENT, THEIR NAME _____
9. THEIR BIRTHDATE: _____/_____/_____ THEIR ADHAR NO._____
10. WHAT IS THEIR RELATIONSHIP TO PATIENT? _____Spouse _____Parent _____OTHER
11. THEIR ADDRESS, if different from patient: _____, _____,
    THEIR
12. HOME PHONE:(_____)_____ WORK: (_____)_____CELL: (_____)_____
13. CELL:
14. IF INSURANCE IS THROUGH AN EMPLOYER, WHO IS THE EMPLOYER? _____ EMPLOYERS
    ADDRESS: _____
15. OTHER INSURANCE? YES NO IF NO, SKIP TO EMERGENCY CONTACT INFORMATION SECTION
    IF YES, INSURANCE CO:_____ID#:_____GROUP#_____
    IF INSURANCE IS **THROUGH** SOMEONE OTHER THAN PATIENT, THEIR NAME: _____
    THEIR BIRTHDATE: _____/_____/_____ THEIR SOC. SEC. #:_____
    WHAT IS THEIR RELATIONSHIP TO PATIENT?___ Spouse___ Parent __Other
16. PRIMARY PHYSICIAN'S NAME / ADDRESS / PHONE:

_____

_____

17. WHO REFERRED YOU TO THIS OFFICE?

_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT:_____

ADDRESS_____, _____, _____. _____

HOME PHONE: (_____)_____ WORK: (_____)_____CELL: (____)_____

I understand that I am financially responsible for all charges for services provided to me. I authorize payment of medical benefits to myself or the names provided for professional services rendered. I authorize the release of any medical information necessary to process my claims.

_____ _____ _____

Patient Signature Date Printed Name