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:_____