REGISTRATION FORM

Patient:

_____

First Name **MI** **Last Name**

Home Phone: ( ) _____

Cellular: ( ) _____

Responsible Party (if minor) _____ Relationship: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Age: _____ **Birth date**: _____ **Marital Status**: **() Single () Married () Widowed () Divorced**

Social Security #: _____ Education level: _____

EMAIL ADDRESS: _____@ _____

EMPLOYMENT INFORMATION

Place of employment: _____ Position: _____

Work Phone: ( ) _____ Ext: _____

INSURANCE INFORMATION

Primary Insurance: _____ _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____ Telephone: _____

Policy ID #: _____ **Group #**: _____ **Group Name**: _____

Primary Insured: _____ **Birth date**: _____ **Relationship to patient**: _____

Insured Social Security #: _____

EMERGENCY CONTACT

Spouse or Parent (if minor): _____ Spouse Date of Birth: _____

Spouse Work Phone: ( ) _____ **Cellular Phone**: ( ) _____

Emergency/Alternate contact: _____ Phone: ( ) _____

Relationship to Patient: _____ Alt Phone: ( ) _____

CHILDREN INFORMATION

Child Name	Gender	Birth date
(1) _____	**F ( ) M ( )**	_____
(2) _____	**F ( ) M ( )**	_____
(3) _____	**F ( ) M ( )**	_____

MEDICATION ALLERGIES:

Allergies: _____ **Reaction:** _____

PHARMACY: _____

Address: _____

Phone Number: ( ) _____

PRIMARY CARE PHYSICIAN

Name: _____ **Phone: ( )** _____