New Patient Registration Form

Today's Date	**Please Print**

PATIENT INFORMATION

Full legal Name(First) (Middle) (Last)			Name Normally Used (Nickname)	
Address	Apt. No.	City	State	Zip
E-mail address	Home Phone	Work Phone	Cell Phone	
Social Security No.	Maritial Status	Date of Birth	Driver's License No.	State Issued
Employer Name	Employer City	Employer State	How did you hear about us?	
List anyone you authorize this office to share your medical information with (Name and relationship to you)				
Permitted contact method(s) (circle all that apply) home phone cell phone work phone mail e-mail		Ok to leave message on answering machine/voicemail? Yes_____ No_____		

SPOUSE'S INFORMATION

Full legal Name(First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work Phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient is a child)	Policy Holder's Social Security No.	Policy Holder's date of birth
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name	Policy Holder's Social Security No.	Policy Holder's date of birth

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1 Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.

2 Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

Patient/Guarantor Signature:_____ Date:_____