# Welcome!

REGISTRATION FORM

**SECTION I** **PATIENT INFORMATION** **Date** _____

Name _____ I Prefer to be called _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

The best time to contact me is _____ ❑ A.M. ❑ P.M. on my ❑ Home phone ❑ Work phone ❑ Cell phone

Date of Birth _____ Social Security Number _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

If Student, Name of School _____ City/State _____ ❑ FT ❑ PT

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

Email Address _____ Would you like to receive our e-newsletter? ❑ Yes ❑ No

**SECTION II** **RESPONSIBLE PARTY**

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (____) _____ SSN# _____

**SECTION III** **INSURANCE INFORMATION**

Name of Insured _____ DOB _____ Relationship to Patient _____

Employer _____ Work Phone (____) _____ SSN# _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Grp# _____ ID# _____

Ins Co Address _____ Ins Co. Phone (____) _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ DOB _____ Relationship to Patient _____

Employer _____ Work Phone (____) _____ SSN# _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Grp# _____ ID# _____

Ins Co Address _____ Ins Co. Phone (____) _____

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