Patient Registration Form

Patient information

Name________________________________
Dr Mrs Ms Mr
I prefer to be addressed as_____________
Date of Birth ____/____/____
SS# ____-____-____
Address______________________________
____

Marital Status__________________________
Home #_______________________________
Work # _______________________________
Email ______________________________
Occupation _______________________
Employer _______________________

We use an automated courtesy reminder for appointments & use emails to communicate with our patients. Please indicate below your preferred method of communication:
❐Text ❐Email ❐Neither

How did you hear about our office?
____
Do you have family members who are our patients?___________________________
Whom may we thank for referring to you?
____

Emergency contact person
Name _____________________________
Relationship_________________________
Phone______________________________

Account Information

Person responsible for your account (Name)
____
Relationship to you____________________

Insurance Carrier______________________

Subscriber’s name
____

Subscriber DOB______________________
Group/Member ID____________________
Do you have additional insurance?_______
____
Email of Responsible party
____

For Minors

School___________________________
Name of responsible party
____

Relationship to child_________________
Phone ___________________________

Who will accompany the minor patient(s) to appointments?_______________________

Today’s date________________________