PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE_____
      FIRST   MI   LAST

ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C._____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY_____ STATE/ PROV._____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY_____ STATE/ PROV. _____ ZIP/ P.C._____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL #_____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY_____ STATE/ PROV. _____ ZIP/ P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. #_____

INS. CO. ADDRESS _____ CITY_____ STATE/ PROV. _____ ZIP/ P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO   IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL #_____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY_____ STATE/ PROV. _____ ZIP/ P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. #_____

INS. CO. ADDRESS _____ CITY_____ STATE/ PROV. _____ ZIP/ P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT?_____

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____ PATIENT NUMBER

REGISTRATION