

## PATIENT REGISTRATION FORM

(Please fill in every blank, especially bold areas, including back of form.)

ATTENDING PHYSICIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

<b>PATIENT NAME</b> <small>Include maiden name or middle name</small>			
<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>HOME PHONE</b> (    )	<b>WORK PHONE NO.</b> (    )	<b>EXT</b>	<b>OCCUPATION</b>
EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED			
EMPLOYER'S NAME AND ADDRESS			
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS (CIRCLE ONE) MARRIED    WIDOWED    SEPARATED SINGLE    DIVORCED	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY NO.</b>
NAME OF SPOUSE			
WHOM MAY BE THANK FOR YOUR REFERRAL			

### SPOUSE AND/OR RESPONSIBLE PARTY (if other than patient)

<b>RESPONSIBLE PARTY'S NAME</b>		<b>RELATIONSHIP TO PATIENT</b>	<b>DATE OF BIRTH</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
RESPONSIBLE PARTY'S EMPLOYER NAME & ADDRESS			
<b>RESP. PARTY HOME PH. NO.</b> (    )	<b>RESP. PARTY WORK PH. NO.</b> (    )	<b>RESP. PARTY'S SOC. SECURITY NO.</b>	<b>OCCUPATION OF RESP. PARTY</b>
<b>FRIEND OR RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY</b>			
NAME _____		RELATIONSHIP _____	
ADDRESS _____		PHONE NUMBER _____	

### INSURANCE INFORMATION

Code: \_\_\_\_\_

Code: \_\_\_\_\_

<b>PRIMARY INSURANCE CARRIER</b>		<b>SECONDARY INSURANCE CARRIER</b>	
<b>BILLING ADDRESS</b>		<b>BILLING ADDRESS</b>	
<b>SUBSCRIBER NAME</b>	<b>SS#</b>	<b>DATE OF BIRTH</b>	<b>DATE OF BIRTH</b>
PATIENT'S RELATIONSHIP TO SUBSCRIBER		PATIENT'S RELATIONSHIP TO SUBSCRIBER	
<b>POLICY I.D. NO.</b>	<b>GROUP NO. / GROUP NAME</b>	<b>POLICY I.D. NO.</b>	<b>GROUP NO. / GROUP NAME</b>
<b>INSURANCE CO-PAYMENT</b>		<b>INSURANCE CO-PAYMENT</b>	
DO YOU HAVE A PRESCRIPTION CARD? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHARMACY NAME AND PHONE NUMBER	
DO YOU HAVE AN ADVANCE MEDICAL DIRECTIVE? (LIVING WILL AND/OR DURABLE POWER OF ATTORNEY FOR HEALTHCARE) <input type="checkbox"/> YES <input type="checkbox"/> NO			

ALLERGY TO MEDICATION: \_\_\_\_\_ PRESENT MEDICATIONS: \_\_\_\_\_

(OVER)