NEW PATIENT REGISTRATION FORM

Last Name: ________________________________ **First Name:** ____

Address: _________________________________ **City:** ____

State: ___________________________________ **Zip Code:** ____

DOB: ____________________________________ **Social Security #:** ___________________________________

Home Phone: _____________________________ **Cell Phone:** ____

Email: ____

Marital Status: Married Single Widowed Divorced

Emergency Contact: ________________________________ **Relationship:** __________________________________

Tel:_________________________ **Address:** ____

City:______________________**State:**______________________________**Zip:** ______________________________

Medical Insurance Information (Please present insurance card on the day of appointment)

Primary Insurance: ______________________________ **Policy #:**____________________________________

Group # ______________________________ **Insured Name:** ____

DOB: ___________________________ **Relationship to patient:** SELF SPOUSE

Secondary Insurance: ___________________________ **Policy #:** ____

Insured Name: _________________________________ **DOB:** ____

Group # ___________________________ **Relationship to patient:** SELF SPOUSE

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Patient Employer: ______________________________________ **Occupation:** ______________________________

Employer Address: ____________________________________ **Work Tel:** ________________________________

City: ____ **State:** __________________**Zip:**_____________________

I understand and agree that I will be RESPONSIBLE for payments of all charges incurred. We request that all office visits be paid at the time of service. We look to you for payment of any services rendered. We do not hold secondary insurance companies responsible for payment.

Patient Signature: _______________________________________ **Date:** ___________________________________