

Patient Registration Form

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Patient's Information			
Last Name:	First Name:	Date of Birth (MM/DD/YYYY):	
Mailing Address:			
City/State/Zip:		Home phone:	
Cell phone:	Social Security Number (SSN):	Occupation/Employer:	Biological Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status:	If Married Spouses Name:		
Email:			
Responsible Party <small>-if the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor</small>			
Last Name:	First Name:	Date of Birth (MM/Day/Year):	
Mailing Address:		Phone Number:	
City/State/Zip:		Relationship to Patient:	
Medical History			
List Allergies to any Medications:		Present Medications:	
All Known Medical Conditions:		Chief Problem Today:	
Primary Medical Insurance		Secondary Medical Insurance	
Ins. Co. Name		Ins. Co. Name	
Policy Holder Name:		Policy Holder Name:	
Policy Holder's ID #:		Policy Holder's Date of Birth:	
Is This Workmans Comp.: <input type="checkbox"/> Yes <input type="checkbox"/> No	Workmans Comp. Case #:	Please provide insurance cards to office staff so that they may make copies for your file.	
Preferred Pharmacy			
Pharmacy Name:		Pharmacy Phone Number:	
		City, State, Zip:	
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S). I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I ACKNOWLEDGE THAT I HAVE RECIEVED A COPY OF THE HIPPA PRIVACY PRACTICES.			
Signature			
Patient Signature (or Guardian):			Date: