PATIENT REGISTRATION
Private Insurance & Non-Insured
(Please Print)

Patient Information

Name_____ SS#_____
Last First MI
Address_____ City_____ State____ Zip_____
Home Ph_____ Cell Ph_____ Work Ph_____
E-mail_____ Driver's Lic. #_____
Sex □ M □ F Age_____ Birthdate_____ □ Single □ Married □ Other
Patient Employed By_____ Occupation _____
Referred By: □ Doctor_____ □ Friend/Relative □ Advertisement □ Phonebook □ Employer
□ Return Visit □ Sign of Building □ Internet/Website □ Other_____
Name of Spouse_____
In case of emergency, who should be notified?_____ Ph_____

Primary Insurance

Responsible Party / Subscriber Name _____
Last First MI
Relation to Patient_____ Birthdate_____
Responsible Party / Subscriber Employed By_____ Occupation _____
Insurance Company_____ Driver's Lic. # & State _____
Contract #_____ Group #_____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No
Subscriber Name_____ Relation to Patient_____ Subscriber's Birthdate _____
Subscriber Employed By_____ Business Ph _____
Insurance Company_____
Contract #_____ Group # _____ Subscriber # _____

Name of person completing this form_____ Date_____

A signed Arbitration Agreement is also required prior to treatment