

**PATIENT REGISTRATION FORM**

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

NAME: \_\_\_\_\_  
Last First Middle Maiden

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_ S.S.# \_\_\_\_\_ Gender: M F

ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ OK to call home: YES NO

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ DEPT: \_\_\_\_\_  
WK PHONE: \_\_\_\_\_ Message ok at work: YES NO

INSURANCE COMPANY: \_\_\_\_\_  
CONTRACT NUMBER: \_\_\_\_\_ GROUP \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
\*SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.# \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_  
CONTRACT NUMBER: \_\_\_\_\_ GROUP \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
\*SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.# \_\_\_\_\_

*In case of an emergency, who should we notify?* \_\_\_\_\_  
Name Phone

Do you have an advance directive or living will?  Yes  No  
Date given to our office \_\_\_\_\_ Information given to patient: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ Religious Affiliation: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Separated \_\_\_\_mo/yrs  
Spouse/Partner Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Level of Education: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Parent/Guardian Information** (complete if patient is a minor)

NAME: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

\* Insurance information must be complete, including SSN and date of birth for subscriber.

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