



PATIENT REGISTRATION

Today's complaint: _____

Visit Date: _____

Patient	Last Name: _____ First Name: _____ Middle: _____		
	Address: _____		
	City: _____	State: _____	Zip: _____
	Home Phone: _____	Work Phone: _____	Cell Phone: _____
	Preferred Message Phone: _____		SSN: _____
	Date of Birth: _____	Age: _____	Marital Status: _____ Sex: _____
	Employer: _____		

Health Insurance	Primary Insurance: _____		Effective Date: _____
	Group Number: _____		Subscriber Number: _____
	Policy Holder Name: _____		Date of Birth: _____
	Employer: _____		Relationship to Patient: _____
	Insured SSN: _____		
	Secondary Insurance: _____		Effective Date: _____
	Group Number: _____		Subscriber Number: _____
	Policy Holder Name: _____		Date of Birth: _____
Employer: _____		Relationship to Patient: _____	

Responsible Party	Last Name: _____ First Name: _____ Middle: _____		
	Address: _____		
	City: _____	State: _____	Zip: _____
	Home Phone: _____	Work Phone: _____	Cell Phone: _____
	Preferred Message Phone: _____		SSN: _____
	Date of Birth: _____	Marital Status: _____	Sex: _____
	Employer: _____		Relationship to Patient: _____

In Case of Emergency	Last Name: _____	First Name: _____	
	Address: _____	City/State: _____	Zip: _____
	Relationship to Patient: _____	Phone Number: _____	

Primary Physician	Name of Personal Physician: _____	Phone Number: _____
	Physician: _____	

How did you hear about us? ___ Radio ___ TV ___ Newspaper ___ Friend/Co-worker ___ Internet ___ Yellow Pages ___ Doctor

(OVER PLEASE)

Medications and dosages: (including over the counter)	Allergies:
1	
2	
3	
4	Hospitalizations:
5	1
6	2
7	3
8	4
Medical History/Injuries	5
	Surgeries:

Immunizations: When did you last have?

Tetanus: _____

Flu: _____

Hep B: _____

Family History

(Check items that apply)

Heart Failure (Weak Heart):			Thyroid Disease:	
High Blood Pressure (Hypertension):			Glaucoma:	
Heart Attack or Angina:			Osteoporosis:	
Stroke:			Migraine Headaches:	
High Cholesterol:			Depression:	
Diabetes:			Cancer:	
Emphysema:			Alcoholism:	
Asthma:			Trouble with blood	
			not clotting:	

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice. *I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.* In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Photocopy of this agreement shall be as valid as the original.

SIGNATURE

DATE