**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Name: Last_____First_____Middle_____

Date of birth____/____/____ Male____Female____ Social Security Number _____-_____-_____

Address_____

City, State, ZIP_____

Phone(s): Home_____Cell_____Other_____

E-mail address_____

Employment: Unemployed_____Full-time student_____Part-time student_____Employed_____

Employer_____Occupation_____

**RESPONSIBLE PARTY INFORMATION (E.G. PARENT OR GUARDIAN)**

Name: Last_____First_____Middle_____

Documentation of identity (copy will be kept securely in patient's chart): Driver's license_____

Social security number_____Passport_____Utility bill_____

Address_____

City, State, ZIP_____

Phone(s): Home_____Cell_____Other_____

Email address_____

Employment: Employed_____Unemployed_____Full-time student_____Part-time student_____

Occupation_____Employer_____Employer's phone_____

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**_____

Name of insured_____Relationship to patient_____

Insurance company: Name_____Phone(_____)_____

Insurance company address:_____

Subscriber ID (Policy number)_____Group ID_____Copay $_____

Effective date_____Termination date_____

DOB of insured_____ (Copy of current insurance card to patient chart)

**SECONDARY INSURANCE**_____

Name of insured_____Relationship to patient_____

Insurance company: Name_____Phone(_____)_____

Insurance company address:_____

Subscriber ID (Policy number)_____Group ID_____Copay $_____

Effective date_____Termination date_____

DOB of insured_____ (Copy of current insurance card to patient chart)