REGISTRATION FORM

(Please Print)

Provider:

PATIENT INFORMATION

Today's Date:_____

Patient's Name: ☐ Mr. ☐Miss Marital Status:
☐ Mrs. ☐ Ms.
☐Single ☐Mar ☐Partnered ☐Div ☐Sep ☐Wid

_____
LAST **FIRST**

Sex: M F Birth Date:_____ Age:_____ Social Security #_____

Street Address:_____

P.O Box:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Other family members seen here:_____

INSURANCE INFORMATION

(Please give your insurance card to the provider.)

_____
Person Responsible for Bill Birth Date Home Phone

_____
Address (if different from patient)

Is this person a patient here? ☐ Yes ☐ No

_____
Employer Primary Care Dr. Dr. Phone #

Is this person covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: Name of Insurance Co._____

_____
Subscriber's Name | Subscriber's Birthdate | Subscriber's SS# | Policy Number | Group Number

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Co-Pay: $_____

Name of secondary insurance (if applicable): _____

_____
Subscriber's Name Policy Number Group Number

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

_____
Patient/Guardian signature Date

For office use only:

DSM_____Intake date (90801)_____Charge:_____Service_____