REGISTRATION FORM

PATIENT INFORMATION

Patient Name:_____ **Nickname:**_____

Birth Date:_____ **Sex: M F** **Marital Status: S M D W** **Email:**_____

Social Security #:_____ **Home Phone:**_____ **Cell Phone:**_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

Employer:_____ **Occupation:**_____

Spouse Name:_____ **Spouse Phone Number:**_____

How did you hear about us:_____

RESPONSIBLE PARTY

Name:_____

Birth Date:_____ **Sex: M F** **Marital Status: S M D W**

Social Security #:_____ **Home Phone:**_____ **Cell Phone:**_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

PRIMARY INSURANCE

Employee Name:_____ **Employee SSN:**_____

Employee Birth Date:_____ **Employer:**_____

Insurance Company:_____ **Group #:**_____

Claims Address:_____

City:_____ **State:**_____ **Zip:**_____

SECONDARY INSURANCE

Employee Name:_____ **Employee SSN:**_____

Employee Birthdate:_____ **Employer:**_____

Insurance Company:_____ **Group #:**_____

Claims Address:_____

City:_____ **State:**_____ **Zip:**_____

CONSENT

I consent to treatment as deemed necessary and desirable, and authorize the doctor or designated staff to perform those services. I acknowledge full responsibility for payment of treatment rendered.

_____ (Signature Required)