

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE: \_\_\_\_\_  
FIRST MI LAST  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ [ ] MALE [ ] FEMALE  
CHECK APPROPRIATE BOX: [ ] MINOR [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ] SEPARATED  
IF COLLEGE STUDENT; F.T./P.T., NAME OF SCHOOL: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
PATIENT'S OR PARENT'S/ GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
SPOUSE OR PARENT'S/ GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? [ ] YES [ ] NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
INSURANCE CARRIER \_\_\_\_\_ TEL# \_\_\_\_\_ GRP# \_\_\_\_\_ POLICY/ ID# \_\_\_\_\_  
INS. CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ MAX ANNUAL BEBENFITS? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE [ ] YES [ ] NO IF YES, PLEASE COMPLETE THE FOLLOWING:**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
INSURANCE CARRIER \_\_\_\_\_ TEL# \_\_\_\_\_ GRP# \_\_\_\_\_ POLICY/ ID# \_\_\_\_\_  
INS. CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

X \_\_\_\_\_ SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF MINOR

REGISTRATION