Patient Registration

Chart No | | | | | | | Today's Date [_____/____/_____]

PATIENT INFORMATION

Please complete the requested information below.

Full Name _____ (Last / First / MI) Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Home Address _____ Age _____ Sex [ ] Male [ ] Female

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Date of Birth _____ Driver's License _____ / _____ (Number / State)

Emergency Contact

Emergency Contact _____ Phone _____

Relationship to Patient _____ (for example, Mother, Husband, etc)

PAYMENT PREFERENCE

Payment is due at time services are rendered. Co-payments, coinsurance, and cash payments can be made by any of the payment preferences below.

Payment Method [ ] Cash [ ] Check [ ] Visa [ ] Discover [ ] MasterCard [ ] American Express [ ] Care Credit [ ] Debit Card [ ] ChaseHealthAdvance

Credit Card N0 [_____] Exp Date (mm/yyyy) [____/_____] Security Code [_____]

Card Billing Address _____

POLICY HOLDER INFORMATION

Name of Insured _____ (Last / First / MI.) Relationship [ ] Self [ ] Child [ ] Spouse [ ] Other

Social Security No _____ Date of Birth _____

Employer's Name _____ Member ID No _____

Insurance Company _____ Group No _____

Insurance Address _____ Insurance Phone _____

SOURCE OF REFERRAL

[ ] Family/Friend [ ] Website [ ] Mail [ ] Phone Book [ ] Hospital [ ] Other [ ] Sign

Reason for visit _____