Patient Registration Form

Patient Information

PATIENT INFORMATION

Last Name:	First Name: M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #
City/State/Zip:	**Personal email to communicate via confidential patient portal:**	
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact (reminders/ other electronically generated messages) (Select One Option) ☐ Voice ☐ Text Permission to leave a message regarding your medical care & test results? YES / NO		If Voice select one ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician or Pediatrician:
School/Employer Name:	Marital Status: Single / Married / Divorced / Widowed / Partner	
Emergency Contact Name:	Emergency Contact Phone #:	Relationship to Patient:
Permission to speak to Emergency contact?	Name/Relationship of Immediate Family Members we have permission to speak with:	

Parent/Guardian Information

MINOR (<18 years) PARENT INFORMATION / ADULTS (<26 years) COVERED UNDER PARENTS INSURANCE

Financially Responsible Party – the parent or legal guardian bringing in the minor will be financially responsible, and asked to sign Financial Agreement

Parent Information

Last Name:	First Name: M.I.	Previous Name (if Applicable)
Mailing Address:		Apt #
City/State/Zip		
Home Phone:	Cell Phone:Pt	Work Phone:
Date of Birth:	Sex: ☐ Male ☐ Female	Relationship to Patient:
Marital Status:	Social Security:	**Personal Email:**

Second Parent Information

Last Name:	First Name: M.I.	Previous Name (if Applicable)
Mailing Address:		Apt #
City/State/Zip		
Home Phone:	Cell Phone:	Work Phone:
Date of Birth:	Sex: ☐ Male ☐ Female	Relationship to Patient:
Marital Status:	Social Security:	**Personal Email:**

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance	
Ins. Co. Name	Ins. Co. Name	
Policy Holder Name:	Policy Holder Name:	
Policy Holder's Date of Birth	Policy Holder's Date of Birth	
Policy Holder's Social Security #:	Policy Holder's Social Security #:	
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:	
Employer Name / ID / Group #	Employer Name / ID / Group #	
Is this a Worker's Comp Injury? ☐ Yes ☐ No	If Yes, Date of Injury?	Claim #:
WC Ins. Co Name:	Street Address:	
City/State/Zip:	Phone:	
Contact Person/Case Manager:	Contact Phone#:	

Signature of Responsible Party: **x** _____ Date: _____

Printed Name of Responsible Party: **x** _____ Date: _____