

Welcome!

REGISTRATION FORM

| Section I: | Patient Information | Date _____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------|
| Name: _____ I Prefer to be called: _____ | | |
| Address: _____ City: _____ State: _____ Zip _____ | | |
| Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____ | | |
| The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone | | |
| Date of Birth: _____ Social Security Number: _____ | | |
| Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | | |
| If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT | | |
| Spouse or Parent's Name: _____ Employer _____ Work Phone _____ | | |
| Whom may we thank for referring you? _____ | | |
| Person to contact in case of emergency _____ Phone _____ | | |
| Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| Section II | Responsible Party |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | |
| Name: _____ Relationship to Patient: _____ | |
| Address: _____ | |
| City: _____ State: _____ Zip: _____ Phone: (____) _____ | |
| Employer _____ Work Phone (____) _____ SSN# _____ | |

| Section III | Insurance Information |
|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| Name of Insured _____ DOB _____ Relationship to Patient _____ | |
| SSN#: _____ Name of Employer: _____ Work Phone: (____) _____ | |
| Address of Employer: _____ City _____ State: _____ Zip _____ | |
| Insurance Company _____ Grp # _____ ID# _____ | |
| Ins Co Address: _____ Ins Co. Phone: _____ | |
| ----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING ----- | |
| Name of Insured _____ DOB _____ Relationship to Patient _____ | |
| SSN#: _____ Name of Employer: _____ Work Phone: (____) _____ | |
| Address of Employer: _____ City _____ State: _____ Zip _____ | |
| Insurance Company _____ Grp # _____ ID# _____ | |
| Ins Co Address: _____ Ins Co. Phone: _____ | |