Patient Registration Form

Name: Last	First	Middle Initial
♡ Email:		Today's date:
Preferred Name or Nick Name:		
Address:	City:	State: Zip:
♡ Cell phone: ( ) ♡ Text	♡ Home: ( ) ♡	Work: ( )
Social Security #:	Date of Birth:	Sex: M F
Emergency Contact:	Phone: ( )	
Marital Status: ❒ Married ❒ Single	❒ Divorced ❒ Widowed	
Preferred Pharmacy:	Favored method for confirmations? (check a ♡)	
How did you find out about us?	Can we text your cell phone with urgent information? (for example, a schedule cancellation that might mean you get seen for important treatment sooner?) ❒ Yes ❒ No Note: If you select Texting, carrier's message rates apply	

Insurance Information

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST

Primary Insurance Information			
Name of Insured		Employer	
Relationship to Patient	❒ Self	Insurance Company	
	❒ Spouse	Ins. Co. Phone	
	❒ Child	Ins. Group Name	
	❒ Dependent	Group #	
		ID #	

Secondary Insurance Information			
Name of Insured		Employer	
Relationship to Patient	❒ Self	Insurance Company	
	❒ Spouse	Ins. Co. Phone	
	❒ Child	Ins. Group Name	
	❒ Dependent	Group #	
		ID #	