

OFFICE USE ONLY

DATE  
UPDATED \_\_\_\_\_

**Patient Registration** ( Please Print )

Referred by \_\_\_\_\_ Date \_\_\_\_\_

<b>P A T I E N T</b>	Mr. Mrs. Miss				
	Patient	Last Name	First Name	Middle	
	Social Security #	Date of Birth	Sex	Marial Status	Home Phone
	Address	Street	Apt. No.	City	State Zip
	Employed By	Spouse's Name		Employed By	
	Employer's Address		Employer's Address		
	Occupation	Bus. Phone	Occupation	Bus. Phone	
		Spouse's Social Security #		Date of Birth	

<b>I N S U R A N C E</b>	<b>INSURANCE INFORMATION</b> (Be sure all information is listed)		
	Insurance -- Include Private, Group, and Spouse		
	Insurance Company Name	Policyholder (Subscriber)	Policy Number or Certificate Number
	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
	Will this claim be covered under Worker's Compensation?		Yes _____ No _____
If yes, Name of Company _____		Address of Co. _____	
Ph. # _____	Treatment Authorized by _____		

<b>R E S P O N S I B L E  P A R T Y</b>	<b>RESPONSIBLE PARTY</b>				
	Mr. Mrs. Miss				
	Name	Address	City	State	Zip
	Home Phone	Relationship to Patient		Occupation	
	Employer	Employer's Address	City	State Zip	Bus. Phone
	I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.				
	I understand that where appropriate, credit bureau reports may be obtained.				
Date (today)	Signature of Patient, or Parent, or Responsible Party				