

PATIENT REGISTRATION FORM
Please Print Legibly

CIC _____

PATIENT

| | | | | | | | | |
|------------------------------------|--|------------------|------------|------|--------------------------------------|-------------|----------------|------------------------|
| Today's Date | | Referring Doctor | | | How did you hear about our Facility? | | | Race |
| Last Name | | | First Name | | | Middle Name | | |
| Street Address | | | Apt # | City | | | State | Zip Code |
| Home Phone Number | | Cell Number | | Sex | Date of Birth / / | Age | Marital Status | Social Security Number |
| Employer's Name or School | | | | | How Long Employed? | | Phone Number | |
| Employer's/School's Street Address | | | | City | | State | Zip Code | |

PERSON RESPONSIBLE FOR PAYING BILL (GUARANTOR)

(If this is the same as the patient, you may skip this section.)

| | | | | | | | | |
|------------------------------------|--|-------------|-------|------|----------------------|-------|----------------|-------------------------|
| Last Name | | First Name | | | Middle Name | | | Relationship to Patient |
| Street Address | | | Apt # | City | | | State | Zip Code |
| Home Phone Number | | Cell Number | | Sex | Date of Birth / / | Age | Marital Status | Social Security Number |
| Employer's Name or School | | | | | How Long Employed? | | Phone Number | |
| Employer's/School's Street Address | | | | City | | State | Zip Code | |

EMERGENCY CONTACT

| | | | | | | | | |
|-------------------|--|------------|--------|-------------|-------------------------|-------|----------|--|
| Last Name | | First Name | | | Relationship to Patient | | | |
| Street Address | | | Apt. # | City | | State | Zip Code | |
| Home Phone Number | | | | Cell Number | | | | |

INSURANCE INFORMATION

Please present all insurance cards to the receptionist.

| | |
|------------------------------|-------------------------------|
| Policyholder's Name | |
| Policyholder's Date of Birth | |
| Primary Insurance Carrier | Primary Insurance Member ID |
| Secondary Insurance Carrier | Secondary Insurance Member ID |

