



PATIENT REGISTRATION

Date: _____

- Type of Visit:** Urgent Care – Chief Complaint/Symptoms: _____
 Worker’s Compensation – Injury: _____
 K-12 Sports/School PE College - Adult Sports/School PE Wellness Exam
 Pre-Employment Physical DOT Medical Exam Drug Screening
 Other (*Please explain*) _____

Patient	Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Sex: _____ Marital Status: _____ Address: _____ Primary Phone: _____ City: _____ Secondary Phone: _____ State: _____ Zip Code: _____ Would you like to receive emails from us? Y N Email Address: _____ Employer Name/Phone: _____			
Race	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Hispanic or Latino Preferred Language: _____ Do You Need Translation: Y N			
Responsible Party	<i>*Not Required if 18 or over</i> Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Sex: _____ Marital Status: _____ Relationship to Patient: _____ Address: _____ <input type="checkbox"/> Home Phone: _____ City: _____ <input type="checkbox"/> Cell Phone: _____ State: _____ Zip Code: _____ <input type="checkbox"/> Work Phone: _____ Employer Name/Phone: _____			
In Case of Emergency	Last Name: _____ First Name: _____ Middle Initial: _____ Address: _____ Primary Phone: _____ City: _____ Secondary Phone: _____ State: _____ Zip Code: _____ Relationship to Patient: _____			
Health Insurance	<table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"> Primary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____ </td> <td style="width:50%; border:none;"> Secondary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____ </td> </tr> </table>		Primary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____	Secondary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____
Primary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____	Secondary Insurance: _____ Member ID: _____ Group #: _____ Effective Date: ____/____/____ Policy Holder’s Name: _____ Date of Birth: ____/____/____ SSN: ____/____/____ Employer: _____ Relationship to Patient: _____			

Please complete your registration on the back of this form

PATIENT REGISTRATION (Continued)

Primary Physician	Primary Care Physician: _____ City: _____ Phone: _____	
Medications	Please list all medications (with their dosage) that you are currently taking, including over the counter: <i>If you carry a list with you, please allow the registrar to make a copy for our records.</i>	
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	Please list any allergies to medications you have:	
	_____	_____
	_____	_____
	_____	_____

Who referred you to us: _____

How did you hear about us?
 Billboard
 Doctor
 Drive by
 Friend/Relative
 Internet/Web Page
 Phone Book
 Radio
 Television
 Work
 Other _____

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.

In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Photocopy of this agreement shall be as valid as the original.

Signature

Date