REGISTRATION INFORMATION ** Please Read & Complete **

(Please Print)

PATIENT INFORMATION **Date:**_____ **Home Phone:**_____ **Cell:**_____

_____ _____ _____

Name Sex Date of Birth

_____ _____ _____ _____ _____

Address: Street Apartment # City State Zip

_____ _____

Employer Occupation {Circle: Part Time / Full Time }

_____ _____

Business Address Business Phone

_____ _____

E-Mail Address Web/Internet Address (Home page {ie: www.xxx})

Marital Status (circle)

Single Married Widowed Divorced Separated

INSURANCE INFORMATION: Do you have medical insurance?: Yes No

Patient Social Security Number:_____

Name of Insured:_____ **Insured's Date of Birth:**_____

Insured Social Security Number:_____

Insurance Company Name:_____ **Copay: $**_____

Spouse/Responsible Party Employed by:_____

Employer/Business Address and Phone #:_____

Policy Number:_____ **Group Number:**_____

Medicare Number:_____ **Medicaid Number:**_____

MEDICAL INFORMATION:

Emergency Name and Phone #:_____ **Relationship:**_____

MAY WE CONTACT YOU BY PHONE TO CONFIRM APPOINTMENTS &/OR REVIEW TESTS:

Circle : YES NO **Phone Number preferred for contact:**_____

Drugstore Name and Phone :_____

Whom may we thank for referring you?:_____

Known Medical Problems:_____ **ALLERGIES:**_____

Present Medications:_____

Comments:_____

Payment is expected at time of service unless other arrangements have been made prior to services being rendered.

Signature of Patient:_____
(Legal Guardian if Minor)