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REGISTRATION FORM

Patient Information **Date: _____**

Name: _____ I prefer to be called: _____
Address: _____City: _____State: _____Zip: _____
Cell Phone: (_____)_____ Other Phone: (_____) _____ ☐ Home ☐ Work
The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Cell phone ☐ Other phone
Date of Birth: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School: _____City/State: _____ ☐ FT ☐ PT
Spouse or Parent's Name: _____ Employer: _____
Work Phone: (_____)_____Cell Phone: (_____)___
Whom may I thank for referring you? _____
Email Address: _____ Email/text communication ok? ☐ Yes ☐ No
Person to contact in case of emergency: _____Phone: _____

Insurance Information

Name of Insured: _____DOB: _____Relationship to Patient: _____
Name of Employer: _____Work Phone: (_____)_____
Address of Employer: _____City: _____State: _____Zip: _____
Insurance Company: _____ Grp #: _____ID#: _____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING----------

Name of Insured: _____DOB: _____ Relationship to Patient: _____
Name of Employer:_____ Work Phone: (_____)_____
Address of Employer:_____City: _____State: _____ Zip: _____
Insurance Company:_____ Grp #: _____ID#:_____

For Office Use Only

Dx:_____ Co-Pmt:_____
Cov: _____ CPT: _____