



## NEW PATIENT REGISTRATION

<b>Patient Information</b>		
First Name _____	Last Name _____	
Preferred Name _____	Date of Birth _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____	State _____ Zip _____
Soc. Sec #. _____	Driver's License # _____	
Home Phone _____	Work Phone _____	Cell Phone _____
Email _____	Emergency Contact _____	Phone _____

How would you like to receive appointment reminders and correspondence? <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Personal Phone Call
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**Is the patient responsible for payments?**  Yes  No

Responsible Party (if other than patient) \_\_\_\_\_ Relationship to Patient:  Spouse  Parent  Other

<b>Responsible Party</b> <b>**Please fill out this section if patient is <u>NOT</u> responsible party**</b>
First Name _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Employer _____ City _____ State _____ Zip _____
Soc. Sec #. _____ Driver's License # _____ Date of Birth _____
Home Phone _____ Work Phone _____ Cell Phone. _____

### Primary Insurance

### Secondary Insurance

Policyholder Name _____ SSN or Member ID# _____ Policyholder Address (if different from patient's) _____ _____ Ins. Company _____ Group # _____ Employer _____	Policyholder Name _____ SSN or Member ID# _____ Policyholder Address (if different from patient's) _____ _____ Ins. Company _____ Group # _____ Employer _____
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