PATIENT REGISTRATION INFORMATION

Patient's Name ______________________ Today's Date ______________

Address ____
CITY STATE ZIP

Birth Date __________ Age _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Phone ( ) ______________ Work Phone ( ) ______________

Social Security # ______________ Spouse's Name ______________

Family Dr. ______________ Referring Dr. ______________

Family Dr. Address ______________ Referring Dr. Address ______________

Employer ______________ Phone ( ) ______________

Address ____
CITY STATE ZIP

Person Responsible for Bills (If same as patient do not complete) Name ______________ Phone ( ) ______________

Responsible Party's Relationship To Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other ______________

Address ____
CITY STATE ZIP

EMERGENCY CONTACT

NAME	RELATIONSHIP
HOME PHONE ( )	WORK PHONE ( )

INSURANCE INFORMATION - PLEASE GIVE CARDS TO RECEPTIONIST TO COPY

PRIMARY INSURANCE		GROUP #	ID#
INSURANCE ADDRESS			PHONE
SUBSCRIBER NAME (IF DIFFERENT)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Child ☐ Other ______
SECONDARY INSURANCE		GROUP #	ID#
INSURANCE ADDRESS			PHONE
SUBSCRIBER NAME (IF DIFFERENT)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Child ☐ Other ______

If Accident Related Please Provide the Following Information: ☐ Workman's Comp ☐ Auto ☐ Other

Insurance Carrier Name ______________________________

Address ____
CITY STATE ZIP

Date of Accident ______________ State in which Accident Occurred ______________

Policy & Claim #

Policy # ______________ Claim # ______________

Over ➡

ALLERGIES TO MEDICATIONS

Circle any of the following to which you're allergic or have had an unusual reaction to:

Penicillin	Darvon	Latex Allergy
Sulfa Drugs	Codeine	
Erythromycin	Valium (tranquilizers)	
Novacaine (Xylocaine)	Sedatives & Barbiturates	
Motrin	Demerol	
Aspirin	Other ________________	

MEDICAL PROBLEMS

Circle any of the following which you have had:

Mitral Valve Prolapse	Diabetes	Joint Replacement
Heart Trouble	Epilepsy	Stent
Heart Murmur	HIV/AIDS	High Cholesterol
High Blood Pressure	Fainting Spells	Thyroid Problems
Angina	Kidney Trouble	
Stroke	Radiation Therapy	
Congenital Heart Disease	Blood Disorders	
Hepatitis	Ulcers or Lung Disease	
Anemia	Other ________________	

MEDICATIONS

Are you currently taking any kind of medication or drug? ☐Yes ☐No

If yes, please list all medications:

____ ____

____ ____

____ ____

____ ____

____ ____