PATIENT REGISTRATION

DATE: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			**ADDRESS**		
CITY, STATE		**ZIP**	**HOME PHONE**	**CELL PHONE**	
PATIENT DATE OF BIRTH	**PATIENT SSN**	**SEX** ☐ **Male** ☐ **Female**	**MARITAL STATUS** ☐ **Single** ☐ **Married** ☐ **Other**_____		
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**			**EMPLOYER PHONE**	
PATIENT EMAIL ADDRESS					

INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: ❑spouse ❑parent ❑guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		**ADDRESS (if different from patient)**		
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**
IS THIS A WORKER'S COMP CLAIM? (Circle One) Y N		**STATE WHERE INJURY OCCURRED**		**DATE OF INJURY**

PHYSICIAN INFORMATION	
PRIMARY DOCTOR/FAMILY DOCTOR	**REFFERING DOCTOR**

EMERGENCY CONTACT		
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

I give the facility and/or agents permission to send reminders of my appointment by the following method: (Mark all that apply):

_____Cell _____Email ☐ Other (List Below)

_____

Please note: In order to enhance our services, we are offering alternate reminder pathways for your appointments. HIPPA/HIT Privacy rules will be adhered to when applying this method of communication for appointment.

*Your permission is authorizing the facility to send appointment reminders or reschedule information ONLY by the method you have chosen above. This authorization also informs our office we can leave the reminders on voicemail if you are not available to answer. ☐ Opt Out (I do not give the facility and/or agents permission to send reminders of my appointment.)

I agree that the above is true to the best of my knowledge.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

**Cancellations are subject to 24-hour notice. Failure to do so will result in a $25.00 charge.*