

Patient Registration (Please Print)		Date:	
Patient Name:		Date of Birth:	Sex: M / F
Address:		City & State:	Zip:
Home Phone:		Work Phone:	Cell:
SS#:		Occupation:	Spouse
Primary Insurance:	Secondary Insurance:		
Insured's SSN:	Insured's DOB:		
Employer's Name & Address:			
Referred by:	Family Physician:	Phone:	
**I authorize my physician's office to call and leave voicemail or a message with a family member.			
Signature:		Date:	
<b>RESPONSIBLE PARTY: IF OTHER THAN PATIENT</b> (Divorced parents:) It is our policy that the parent accompanying the child for treatment will be held responsible for all charges			
Name:		Relationship to Patient:	
Address:		City & State:	Zip:
Home Phone:		Work Phone:	Cell:
SS#:		DOB:	
Are you Retired?		Employer's Name & Address:	
<b>NEAREST RELATIVE NOT LIVING WITH THE PATIENT</b>			
Name:		Relationship to Patient:	
Address:		Home Phone:	
<b>X</b>			
<b>SIGNATURE OF RESPONSIBLE PARTY</b>			