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PATIENT REGISTRATION

Name _____ M / F DOB _____
Last First MI month/day/year
Street Address _____
City, State, Zip Code _____

Referred By: _____

Family Structure:

Mother's Name _____
Home Address _____
Cell phone _____ Home phone _____ S.S. # _____
DOB _____ Occupation _____
Employer _____ Work phone _____

Father's Name _____
Home Address _____
Cell phone _____ Home phone _____ S.S. # _____
DOB _____ Occupation _____
Employer _____ Work phone _____

Guarantor
Name _____ Relationship to child _____
Home Address _____
Cell phone _____ Home phone _____ S.S. # _____
DOB _____ Occupation _____
Employer _____ Work phone _____

Emergency Contact (other than parents):

_____
(Name) (Phone Number) (Relationship to Parent or Child)

INSURANCE & BILLING INFORMATION

We must have your insurance information at the time of your visit in order to ensure our participation.
If we do not participate with your current insurance plan, YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME SERVICE IS RENDERED. You are responsible for any co-insurance, deductible and co-payments based on your plan. If your insurance requires you to pay a co-payment, this must be done at the time service. You understand that you are financially responsible for any services that are not covered by your insurance plan(s). I have read the above information and understand my financial obligations.

Responsible Party's Signature with Date: _____
Patient's Name with Date of Birth: _____