

REGISTRATION INFORMATION

PLEASE PRINT

NEW HEALTHCARE MANDATES REQUIRE ALL PATIENT REGRISTRATION INFORMATION FIELDS TO BE COMPLETED:

Date: _____

PARENTS INFORMATION

Father: _____
(Last Name) (First Name) (Initial)

Home Address: _____

Home Phone: _____ Cell: _____

Employed by: _____

Business Address: _____

Occupation: _____ Phone: _____

Social Security# _____ Date of Birth: _____

Mother: _____
(Last Name) (First Name) (Initial)

Home Address: _____

Home Phone: _____ Cell: _____

Employed by: _____

Business Address: _____

Occupation: _____ Phone: _____

Social Security# _____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account?: _____

Address: _____

Phone: _____

What primary pharmacy do you use?: _____
Second pharmacy choice?: _____
Do you have an email address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Policy Holder Name: _____

Secondary Insurance Name: _____
Policy Holder Name: _____

Please present insurance card to receptionist, you will be asked to present your card at each visit.

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

May we leave appointment messages on/with:		leave other medical information on/with:	
Your answering machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Your answering machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile Phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mobile Phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile Text?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mobile Text?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Office Voice Mail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Office Voice Mail?	<input type="checkbox"/> Yes <input type="checkbox"/> No
With another person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	With another person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Through the mail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Through the mail?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Via Email?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Via Email?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered **YES** to allowing us to discuss your appointment and/or medical information with another person, please list the name(s) and relationship(s) with whom we may discuss this information below:
