

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST STATE/PROV. ZIP/P.C.
ADDRESS _____ CITY _____
E-MAIL _____ CELL PHONE _____ HOME PHONE _____
SS#/SIN _____ BIRTHDATE _____
CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
IF COLLEGE STUDENT, E.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ CITY _____ STATE/PROV. ZIP/P.C.
SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. ZIP/P.C.
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. ZIP/P.C.
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. ZIP/P.C.
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. ZIP/P.C.
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

Item 051-5767/27000 Patterson Office Supplies 800-637-1140

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION