

Patient Registration

Referred by:

Last Name	First	MI	Social Security Number	
Address	City	State	Zip	Home Phone
Date of Birth	Sex M F	Spouse Name		
Employed by	How Long	Employed by	How Long	
Employer's Address		Employer's Address		
Occupation	Work Phone	Occupation	Work Phone	
Nearest Relative/Friend Not Living in the Same Household		Relationship	Phone	

Responsible Party

Please complete this section if someone other than the patient is responsible for payment of service.

Name	Address	City	State	Zip
Home Phone	Relationship to Patient	SS#	Occupation	
Employer	Employer's Address		Bus. Phone	

Insurance Information

This information is needed for pre-treatment estimates or for researching a benefit plan.

Name of Insurance Company	Address	City	State	Zip
Policy Holder	Group/Policy#		Bus. Phone	

I have completed this form fully and completely, and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested, I understand that even though I may have insurance coverage, I am responsible for payment of services.

Preferred Method of Payment: Cash Check Visa MasterCard Discover

Signature of Patient or Responsible Party

Date