PATIENT REGISTRATION

Patient Demographics

Patient Name: Last _____ First _____ M.I. ___ Birthdate_____
Parent/Guardian (if under 18) _____
Age _____ Female ☐ Male ☐ Marital Status _____Social Security #_____
Address _____ City _____ State _____ Zip _____
Home Phone# _____ Cell Phone # _____ Work Phone# _____
Would you like to receive your appointment reminder by text? Yes ☐ No ☐
Email Address :_____

(Note: We use your email address for follow-up information that was requested during your counseling session such as recipes, menus and etc. We do not sell or share your email address.)

Would you be interested in receiving general education updates by email? Yes ☐ No ☐
How did you hear about our services? _____
Emergency Contact Name _____ Phone # _____
Relationship to Patient _____

Patient Employment Information

Employer Name _____ Phone # _____
Employer Address _____ City _____ State _____ Zip _____
Occupation _____

Insurance Information

Primary Insurance Company_____
Policy Holder _____ Ph#_____ Birthdate_____
Policy Holder Address_____ City_____ State_____ Zip _____
Policy Holder Employer_____ Phone #_____
Employer Address_____ City_____ State_____ Zip_____
Insurance ID #_____ Group # _____

Secondary Insurance Company _____
Policy Holder_____ Ph # _____ Birthdate _____
Policy Holder Address _____ City _____ State _____ Zip _____
Insurance ID#_____ Group#_____
Note: **Please bring all insurance cards, driver's license, and co-pay to office visit.**

Referral Information

Referring Physician/Healthcare Provider _____ Phone # _____
Address _____City _____State _____Zip _____

Besides your referring physician, is there another healthcare provider you would like to receive a copy of your report?
Name: _____ Phone # _____
Address: _____City _____ State _____Zip _____

Signature _____ Date_____