

Due to new government regulations, please complete all Patient Registration information:

PATIENT REGISTRATION

FIRST NAME:	MI:	LAST NAME:	
STREET ADDRESS		ZIP CODE:	CITY:
HOME PHONE:	WORK PHONE:		CELL PHONE:
PHARMACY NAME & ADDRESS OR PHONE NUMBER:			EMAIL ADDRESS:
SEX: () Male () Female	DATE OF BIRTH:	AGE:	SOCIAL SECURITY #:
REFERRING DOCTOR:	PRIMARY DOCTOR:	DOCTOR'S PHONE NUMBER	
RACE (check one): () White () Black/African America () American Indian/Alaska Native () Asian () Native Hawaiian/Other Pacific Islander () Other () Patient Declined/Unknown			
ETHNICITY: () Spanish/Hispanic Origin () Not of Hispanic Origin () Patient Declined/Unknown		PRIMARY LANGUAGE:	COUNTRY:
		SECONDARY LANGUAGE:	COUNTRY:

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURANCE POLICY HOLDER:	INSURED'S DATE OF BIRTH:	INSURED'S SOCIAL SECURITY #:	
INSURED'S POLICY #:	INSURED'S EMPLOYER:	EMPLOYER CITY/STATE/ZIP:	
INSURANCE GROUP#	YOUR INSURANCE POLICY #:	EFFECTIVE DATE OF INSURANCE:	
RELATIONSHIP TO INSURED:	IF AUTO OR WORK RELATED, DATE OF INJURY:		

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURANCE POLICY HOLDER:	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY #:	
INSURED'S POLICY #:	INSURED'S EMPLOYER:	EMPLOYER CITY/STATE/ZIP:	
INSURANCE GROUP #:	YOUR INSURANCE POLICY #:	EFFECTIVE DATE OF INSURANCE:	
RELATIONSHIP TO INSURED:	IF AUTO OR WORK RELATED, DATE OF INJURY:		

NAME (PRINT): _____

PATIENTS MUST ANSWER ALL QUESTIONS

PRIVACY INFORMATION

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

OK TO LEAVE INFORMATION?

	Appointment Information:	Medical Information:
On home phone (Include Auto Call)?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
On Cell Phone (Include Auto Call)?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
On Office Voice Mail?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
W/ another person?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Send via mail?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Send via e-mail?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name: _____ **Relationship:** _____ **Phone:** _____ **Cell Phone:** _____

Additional HIPAA Contact Instructions:

