PATIENT REGISTRATION

DATE: _____ ACCOUNT #: _____

REFERRED BY: _____

WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST? ☐ YES ☐ NO THANKS

PATIENT'S FULL NAME: _____

SS#: _____ DOB: _____ AGE: _____ CIRCLE ONE: M F

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ FAX #: _____

EMAIL ADDRESS: _____ D.L #: _____

MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP _____

EMPLOYMENT: (If minor, responsible parties)

EMPLOYED BY: _____

POSITION: _____ MAY WE CALL YOU AT WORK? ☐ YES ☐ NO

ADDRESS: _____

MARITAL STATUS:

CIRCLE ONE: MARRIED SINGLE SEPARATED DIVORCED WIDOWED

SPOUSE'S NAME: _____ SS #: _____

SPOUSE'S EMPLOYER: _____ PHONE #: _____

ADDRESS: _____

IN CASE OF EMERGENCY:

NAME: _____

RELATIONSHIP: _____ PHONE #: _____

SECOND CONTACT: _____

RELATIONSHIP: _____ PHONE #: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. PAYMENTS FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. WE ACCEPT CASH, CHECKS, MONEY ORDERS, AND MOST MAJOR CREDIT CARDS. (WE DO **NOT** ACCEPT AMERICAN EXPRESS.)

SIGNATURE: _____ DATE: _____