Patient Registration Form

Last Name	First	MI	DOB	SSN	M/F

Address_______________________________**City**______________**St**____**Zip**_________
Home Phone______________Phone To Contact for Reminder Calls__________________
Patient Cell Phone (Patient over 18)____________________

Mother's Name________________________**SSN**_____________________**DOB**________
Address_______________________________City______________St____Zip_________
Home Phone______________Cell_____________________Work____________________

Father's Name________________________**SSN**_____________________**DOB**________
Address_______________________________City______________St____Zip_________
Home Phone______________Cell_____________________Work____________________

Stepmother's Name____________________SSN_____________________DOB________
Cell Phone____________________________Work______________________________

Stepfather's Name_____________________SSN_____________________DOB________
Cell Phone____________________________Work______________________________

Billing Information(if different from patient's address) Name______________________
Address_______________________________City______________St____Zip_________

Primary Insurance____________________Policy Holder's Name___________________
Subscriber ID Number_________________________Group Number___________________

Secondary Insurance____________________Policy Holder's Name___________________
Subscriber ID Number_________________________Group Number___________________

Local Emergency Contact______________________Relation to Patient________________
Home Phone______________Cell_____________________Work____________________

I hereby consent to treatment for my child, or the above named minor for whom I accept responsibility. I authorize release of information to any insurance carrier and direct payment to this office for any treatment rendered. I hereby acknowledge and accept final responsibility for payment of charges for services rendered, as well as any legal fees incurred by this practice in the event that action need be taken for the collection of such fees.

Signature____Date_____________________