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Client Registration Form

Today's Date: ____

PATIENT INFORMATION
Patient Name: ____ Sex: M [ ] F [ ]
Street Address:
____
City: ____State: ________ Zip Code: _________
Home: (_______)_________________________May I call this number? Y N Leave a message? Y N
Work: (________)________________________ May I call this number? Y N Leave a message? Y N
Cell: (_________)________________________ May I call this number? Y N Leave a message? Y N
Email: ____
Please restrict email to scheduling issues. Do not convey personal information in your email.
SS#:__________________________________Date of Birth:_______________________
Employer:____________________________Occupation:__________________________
Name of Spouse/Partner (if applicable): ____
Person to contact in event of emergency: ____
Phone # of emergency contact: ________________________________
PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT):
____
Billing Address with City/Zip Code:
____
Phone# Home:________________________ Work: _______________________
Relationship to patient: ______________________ Employer_________________
SS#:_________________________________

REFERRAL SOURCE
Name of person referring you to this office:
____

MEDICATIONS (you may attach additional sheet)____

SIGNATURE/AGREEMENT
I,____ , have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout.
Patient or Guardian signature:__________________________________ Date:_______________

If you are using your insurance, please have your insurance card available.