PATIENT REGISTRATION FORM

REASON FOR TODAY'S VISIT

☐ **New Patient** ☐ **Returning Patient**

Chief Complaint – List Symptom(s) here or check a box below (if applicable)	Referred by Doctor	Date

☐ Medical Treatment (list symptoms above)
☐ Work Related Injury – Worker's Compensation
☐ Car Accident or Auto Related Injury
☐ Pre-op Medical Clearance

Physicals:
☐ School, Work Physical, DOT Physical
☐ FAA Physical, Travel Physical
☐ Immigration Physical

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth _____ /_____ /_____ MM DD YEAR

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

☐ **I am a returning patient, there are NO changes to my personal and insurance information in the last 3 months. (NOTE: If you checked this box, you do not have to fill out the below.)**

Mailing / Billing Address	Apt/Unit #	Social Security ___ ___ ___ - ___ ___ - ___ ___ ___ ___
City		Employer

State:	Zip Code:	**Employment Status:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Student ☐ Not Employed

Home Phone: (_____) _____ - _____ Okay to leave voice message? ☐ YES ☐ NO	Cell Phone: (_____) _____ - _____ Okay to leave voice / text message? ☐ YES ☐ NO	Race: ☐ White ☐ Asian ☐ African American ☐ Other_____	Ethnicity: ☐ Hispanic / Latin ☐ **Not** Hispanic / Latin	Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Work Phone: (_____) _____ - _____	**Email:**
Extension:	Providing an email above will allow use for medical communications (patient portal), surveys, & newsletter. Not distributed to third parties. You may to elect to remove at any time.

PRIMARY INSURANCE COMPANY / RESPONSIBLE PARTY

Insurance Company:				
Name of Policy Holder/Responsible Party:	**Policy Holder's Date of Birth:**	Month	Day	Year
Policy Holder's Social Security: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Policy Holder's Relationship to Patient:			
Subscriber Number:	Group Number:			
Check here if **Secondary Insurance** applies: ☐	Secondary Name:			

PATIENT PREFERENCE REGARDING COMMUNICATION OF MEDICAL INFORMATION

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following family member, relative, or other person:

NAME	***RELATIONSHIP***	***PHONE NUMBER***
****NOTE: This individual will be listed as your emergency contact.**		

I hereby **give permission to disclose and discuss** any information related to **my medical condition(s)** with the following family member, relative, or other person:

NAME	***RELATIONSHIP***	***PHONE NUMBER***