Welcome!

REGISTRATION FORM

Please make sure Office Staff copies your insurance/ID Card*

Section I (Patient/Client Information) **Date**_____

Name: _____ Nickname: _____Age_____ **Date of Birth:** _____
Address: _____**City:**_____**State:**_____**Zip**_____
Phone (_____) _____ Work Phone **(_____)** _____ **Cell Phone (_____)** _____
The best number to contact me (or parent) is ☐ Home phone ☐ Work phone ☐ Cell phone
Will you accept texts for appt reminders? ☐ Yes ☐ No Gender_____ Race_____
Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Person to contact in case of emergency_____ **Phone (_____)** _____
Best days of the week and time of day that works best for you for appointments: _____
Do you have other family members who are seen here? _____

Section II (Responsible Party – Spouse or Parent/Guardian info, if client is a child)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name (Printed): _____
Address (If different than above): _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer: _____ Work Phone: _____

Section III (Insurance Information): ***Please circle one:*** ***Medicare** ***BCBS** ***Cash**
***Tricare Prime-Active Duty** ***Tricare Prime-Retired** ***Tricare Standard-Active Duty** ***Tricare Standard-Retired**

Name of Insured/Sponsor: _____**DOB**_____
Relationship to Patient _____ **Sponsor's SSN for Tricare clients ONLY:** _____
Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ **Group #**_____ **ID#**_____

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you and/or your family members

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, YOU MUST COMPLETE THE FOLLOWING:
Insurance Company_____ **Group #**_____ **ID#**_____

YOU MUST inform us immediately if there are any insurance changes, or you may be responsible for payment!

Section IV (Allergies): Please list all known allergies client may have:

_____

_____

Section V (Additional Family members): If you'd like to make an appointment for additional family members, please list them below:

Name	Age	Insurance Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____