OFFICE USE ONLY
NG Account # ___________
MM Account # ___________

PATIENT REGISTRATION FORM (ADULT)

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Miss

Name ______________________________ ❏ male ❏ female

Address ______________________________ Apt# ________

City ____________________ State ______________ Zip ________

Birth Date ______________ Age ______ Social Security # ______-______-______

Home Phone ______________________ Work Phone ______________________

E-Mail ______________________ Cellular Phone ______________________

Employed: ❏ yes ❏ no Employer Name ______________________

Marital Status: ❏ single ❏ married ❏ divorced ❏ widowed

May we leave messages at home with other residents ❏ yes ❏ no

May we leave personal health information on your answering machine/voicemail ❏ yes* ❏ no

May we contact you via e-mail or cellular telephone ❏ yes** ❏ no

** Appointment reminders will be left on voicemail.*

***We cannot ensure the confidentiality of information shared by these means.*

Who may we contact in case of Emergency? Name ______________________

Relationship ______________________ Phone #1 ____________ #2 ____________

Please list below all individuals with whom we may talk to about your medical concerns:

Please Note: *We will not release any personal health information to anyone unless they are listed below*

Name ______________________ Relationship ______________

Name ______________________ Relationship ______________

Name ______________________ Relationship ______________

INSURANCE INFORMATION

Note: *We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.*

Primary Insurance Company ______________________ Co-payment $________

Card Holder Name ______________________ Birth Date ____________

Address ______________________ Social Security # ______-______-______

Is insurance through employer: ❏ yes ❏ no If yes, employer ______________________

Relationship to card holder: ❏ self ❏ mother ❏ father ❏ other

Secondary Insurance ______________________

Card Holder Name ______________________ Birth Date ____________

Address ______________________ Social Security # ______-______-______

Relationship to Card Holder: ❏ self ❏ mother ❏ father ❏ other

Card(s) Copied: Primary: ❏ yes ❏ no Secondary: ❏ yes ❏ no

I understand that when I sign this document that I am confirming that all information completed by me is correct and that any falsification can lead to my dismissal from this practice.

Signature ______________________ Today's Date ____________

HOW DID YOU HEAR ABOUT US?

❏ 411
❏ Brochure
❏ Drive-By Signage
❏ Family or Friends
❏ HealthCALL
❏ Insurance Listing
❏ Phone Book
❏ Postcard
❏ Newspaper
❏ Radio
❏ Shopping Cart
❏ Website
❏ Referring Physician ______________
❏ Other ______________