

PATIENT REGISTRATION

Patient Information

Name: _____ Birthdate: ____ - ____ - ____
SS#: _____ Age: _____ Sex: M or F Marital Status M S W D Other
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell/Work Phone: (____) _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Nearest Relative: _____ Relationship: _____ Phone: _____
Primary Care Physician: _____ Phone Number _____
Referring Physician _____ Phone Number _____
Your Email Address _____
How Did You Hear About Dr. Michaels? _____

Person Responsible for bill (Self if over age 18, legal guardian if under age 18)

Name: _____ Birthdate: ____ - ____ - ____
SS#: _____ - ____ - ____ Age: _____ Sex: M or F Marital Status M S W D Other
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____
Employer: _____ Occupation: _____
Relationship to Patient (only if different): _____

Primary Insurance (Please present card for verification)

Insurance Name: _____ ID# _____
Subscriber Name _____ DOB _____

Secondary Insurance (Please present card for verification)

Insurance Name: _____ ID# _____
Subscriber Name _____ DOB _____