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**_____