



REGISTRATION FORM

PERSONAL INFORMATION:

Date: \_\_\_\_\_

Circle: Mr. Ms. Mrs. Dr. Other: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Street: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Please circle preferred phone number for reminder calls. Home Cell Work

Email Address: \_\_\_\_\_

EDUCATION: Circle highest level of education obtained. Write "some" below highest category if not completed:

Elem Middle High Associates Tech College Masters PhD MD DDS JD DVM Other \_\_\_\_\_

RELATIONSHIP STATUS: Circle Relationship:

Divorced Married Partnered Remarried Separated Single Widowed

BUSINESS OR SCHOOL INFORMATION:

Job Title or Student: \_\_\_\_\_

Business or School Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

FAMILY INFORMATION:

If you are a child give names of parents. If you are married or partnered, give name of significant other.

Name: \_\_\_\_\_ Sex: M F

Name: \_\_\_\_\_ Sex: M F

Relationship: (mother, father, wife, husband, etc)

Relationship: (mother, father, wife, husband, etc)

\_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Please Continue On Back Side of Form

**OTHER FAMILY:**

Please list family members not identified on front side of the form:

First Name	Last Name	Relationship	Date of Birth	Lives with?	
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N
_____	_____	_____	_____	Y	N

**INSURANCE INFORMATION/POLICY HOLDER INFORMATION:**

We will copy your insurance card so please only fill in the policy holder's name, birth date, and phone number.

Primary Ins _____	Secondary Ins _____	Tertiary Ins _____
Group # _____	Group # _____	Group # _____
ID# _____	ID# _____	ID# _____
Policy Holder Name _____	Policy Holder Name _____	Policy Holder Name _____
Birth Date _____	Birth Date _____	Birth Date _____
Phone Number _____	Phone Number _____	Phone Number _____

**RESPONSIBLE PARTY:**

Who should be billed if insurance does not cover services? Give name, etc. if not listed elsewhere on this form.

Circle: Self Spouse Parent Guardian Agency Other \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**REFERRAL INFORMATION:**

How did you hear about us?

- Please circle your choice: on my own, friend, relative, spouse/sig other, therapist at this practice, insurance company, website, advertisement, employer, yellow pages, other: \_\_\_\_\_
- I was referred by: Name: \_\_\_\_\_  
Occupation or title: \_\_\_\_\_  
Business/Organization: \_\_\_\_\_