

## ADULT REGISTRATION AND HEALTH HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Sex M \_\_\_\_\_ F \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Minor \_\_\_\_\_

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

E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ How Long Employed? \_\_\_\_\_

Spouse \_\_\_\_\_ Employer \_\_\_\_\_ How Long Employed? \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Do we have your permission to use your info to text and/or email a message to confirm or otherwise contact you?  yes  no

RESPONSIBLE PARTY: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

Who would we call in case of Emergency? \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured Person \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ ID# \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Annual Maximum Benefit? \_\_\_\_\_ Deductible \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of Insured Person \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ ID# \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Annual Maximum Benefit? \_\_\_\_\_ Deductible \_\_\_\_\_

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