

## PATIENT REGISTRATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_

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

Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number \_\_\_\_\_

Relationship \_\_\_\_\_

**(If your number or address changes PLEASE notify us as soon as possible)**

Employer: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

### **Insurance Information**

If you have a Provider One services card, please list the I D number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Insurance I D number \_\_\_\_\_

Insurance Group number \_\_\_\_\_

Insurance Address \_\_\_\_\_

### **NO SHOW / CANCEL SHORT NOTICE**

**Initial** \_\_\_\_\_ Failure to cancel your appointment within 24 hours may result in a \$50 fee.

**Initial** \_\_\_\_\_ Failure to show up to your appointment may result in a \$50 fee.

**Initial** \_\_\_\_\_ 2 failed appointments will result in a dismissal from our office.