PATIENT REGISTRATION

PATIENT'S NAME ____
First Middle Last

ADDRESS ____

CITY ____________________ STATE ____________ ZIP ____________

HOME PHONE ________________ WORK PHONE ________________ Ext. ______

CELL PHONE ________________ Best time to call ____________________

☐ Male ☐ Female BIRTHDATE ____________ SSN ________________

MARITAL STATUS ☐ Single ☐ Married ☐ Child ☐ Other

EMERGENCY CONTACT: Name ____________ Relationship to Patient ______ Phone ________

EMPLOYER ____________________ OCCUPATION ____________________

EMPLOYER'S ADDRESS ____

EMPLOYER'S PHONE NUMBER ____

RESPONSIBLE PARTY (if other than the patient named above)

Responsible party is the ***patient's*** ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ____________

NAME ____
First Middle Last

ADDRESS ____

CITY ____________________ STATE ____________ ZIP ____________

HOME PHONE ________________ WORK PHONE ________________ Ext. ______

CELL PHONE ________________ Best time to call ____________________

☐ Male ☐ Female BIRTHDATE ____________ SSN ________________

MARITAL STATUS ☐ Single ☐ Married ☐ Child ☐ Other

EMPLOYER ____________________ OCCUPATION ____________________

EMPLOYER'S ADDRESS ____

EMPLOYER'S PHONE NUMBER ____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I understand that I am financially responsible for all fees incurred. I further understand that if the responsible party as listed above denies responsibility, then as the party filling out this form, I am responsible for all fees incurred. I further understand that this account will incur interest at a rate no less than 1.5% per month (18% per year) on unpaid balances over 60 days old.

SIGNATURE ______________________________ DATE ____________
Patient *(parent or guardian, if under 18)*