



PATIENT REGISTRATION

A. PATIENT

Please Print Legibly on Form					Account #	
Last Name		First Name			Middle Initial	
Address		Apt #	City		State	Zip
Home Phone:		Mobile Phone:			Work Phone:	
DOB (mm/dd/yy)		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	SSN #	
E-mail Address						
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Un-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other:						
Employer Name						

B. EMERGENCY CONTACT

Last Name		First Name			Middle Initial	
Home Phone		Mobile Phone			Work Phone	
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Other:						

C. INSURANCE (if applicable)

Primary Insurance (copy of card must be on file)				Check here <input type="checkbox"/> if Name, SSN & DOB same as patient.		
Insurance Name						
Subscriber (Insured) Name					SSN #	
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					DOB (mm/dd/yy)	
Secondary Insurance (copy of card must be on file)				Check here <input type="checkbox"/> if Name, SSN & DOB same as patient.		
Insurance Name						
Subscriber (Insured) Name					SSN #	
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					DOB (mm/dd/yy)	

D. ACCIDENT (if applicable)

Work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Auto or Other Type Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, fill out below)				
Insurance Name					Phone	
Address		City		State	Zip	
Policy #				Agent/Adjuster Name		
Claim #		Accident Date		Accident State		

E. CHIEF COMPLAINT

Please provide specific clinical symptoms and behaviors that support diagnosis. Primary reason for your visit today.



**Patient Registration
Cont.**

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F. ILLNESSES, HOSPITALIZATIONS, SURGICAL PROCEDURES/ (if applicable)

Please list all major illnesses, hospitalizations or surgical procedures:

G. MEDICATION (if applicable)

Please list all medications (prescriptions, over-the-counter and natural/herbal medicines):

H. ALLERGIES(if applicable)

Please list all known allergies including drugs, food animals, etc.:

- ✓ I understand that it is required that I bring to my appointment my Insurance Card and a Photo ID.
- ✓ I have read the Consent to Receive Medical Services-Financial Responsibility Form and I understand that some charges may not be covered by my insurance plan and that I may be responsible for payment, in full, of these charges.

PATIENT PRINTS FULL NAME

SIGNATURE

DATE _____

THANK YOU FOR TAKING THE TIME AND EFFORT TO FILL OUT THIS PATIENT REGISTRATION FORM AS COMPLETELY AND AS ACCURATELY AS POSSIBLE. YOUR INFORMATION WILL ALLOW US TO GIVE YOU THE APPROPRIATE CARE.

REV-SWGHCC12/2015Patient Registration