* Please fill out only the highlighted sections.

REGISTRATION / HISTORY

Date _____

Patient's name _____ Single ____ Widowed ____ Married ____ Long Term Partner ____ Divorced ____ Separated ____

Name of spouse/partner _____

If a child, parent's name _____

Street address _____ Phone _____

City _____ State _____ Zip _____

Patient employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Spouse/Partner employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Purpose of this appointment _____

In case of emergency, who should be notified _____ Phone _____

Who will pay this account _____

Social Security number _____ Birth date _____

Spouse's/Partner's Social Security number _____ Birth date _____

If using Charge Card, name _____ Card no. _____

If welfare, your number _____ County of _____

Do you have insurance that may cover any part of our professional services ..... Yes _____ No _____

If so, name of primary company _____ Policy no. _____

Is policy connected with your union Yes ____ No ____ If yes, name of union _____

Local no. _____ Group no. _____

Social Security no. of policy holder _____

Do you have any other insurance ..... Yes _____ No _____

If so, name of secondary company _____ Policy no. _____

Is policy connected with a union Yes ____ No ____ If yes, name of union _____

Local no. _____ Group no. _____

Social Security no. of policy holder _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _____

Comments: _____

_____

_____

_____

_____

_____

Please complete reverse side

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REGISTRATION / HISTORY

Date _____

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