

REGISTRATION INFORMATION

**** Please Read & Complete ****

(Please Print)

PATIENT INFORMATION Date: _____ Home Phone: _____ Cell: _____

Name Sex Date of Birth

Address: Street Apartment # City State Zip

Employer Occupation {Circle: Part Time / Full Time }

Business Address Business Phone

E-Mail Address Web/Internet Address (Home page {ie: www.xxx})

Marital Status (circle)
Single Married Widowed Divorced Separated

INSURANCE INFORMATION: Do you have medical insurance?: Yes No

Patient Social Security Number: _____

Name of Insured: _____ **Insured's Date of Birth:** _____

Insured Social Security Number: _____

Insurance Company Name: _____ **Copay: \$** _____

Spouse/Responsible Party Employed by: _____

Employer/Business Address and Phone #: _____

Policy Number: _____ **Group Number:** _____

Medicare Number: _____ **Medicaid Number:** _____

(It is required by law that you disclose if you have Medicaid, please note that HRFP does not accept Medicaid)

MEDICAL INFORMATION:

Emergency Name and Phone #: _____ **Relationship:** _____

MAY WE CONTACT YOU BY PHONE TO CONFIRM APPOINTMENTS &/OR REVIEW TESTS:

Circle : YES NO Phone Number preferred for contact: _____

Drugstore Name and Phone : _____

Whom may we thank for referring you?: _____

Known Medical Problems: _____ **ALLERGIES:** _____

Present Medications: _____

Comments: _____

Payment is expected at time of service unless other arrangements have been made prior to services being rendered.

Signature of Patient: _____
(Legal Guardian if Minor)