PATIENT REGISTRATION FORM

PLEASE PRINT

Date_____

Name_____SS#_____

Address_____ Phone ( ) _____

City_____State_____Zip_____

Email address _____Cell Phone ( ) _____

Note* Your email will not be shared with any 3rd parties, and is used for occasional office announcements.

Birth date_____Age_____Sex_____

_____Single _____Married _____Widowed _____Other

Employed by_____

Address_____City_____State_____Zip_____

Employer's Phone number_____

Employer's Email address_____

Name of Parent (if minor)_____

Occupation_____Employed by_____

Address_____City_____State_____Zip_____

Referred by_____

FEES ARE PAYABLE WHEN SERVICE IS RENDERED-PAYMENT METHODS INCLUDE CASH, CHECK, CHARGE. INSURANCE IS NOT ACCEPTED FOR DOT PHYSICALS. WE DO NOT BILL INSURANCE FOR OTHER SERVICES RENDERED IN THIS OFFICE. IF YOU DO HAVE INSURANCE, WE WILL GLADLY GIVE YOU AN ITEMIZED STATEMENT TO PRESENT TO YOUR INSURANCE COMPANY. THANK YOU FOR CHOOSING OUR OFFICE.