Patient Registration Form

Patient Information

Patient's Name (Last)_____ First_____ Middle_____
Social Security Number ____-____-____ Sex F ( ) M ( ) DOB____/____/_____
Phone number: Home ( )_____Cellular( )_____
Address_____

Responsible Party Information

Responsible Party Name (Last)_____First_____Middle_____
Social Security Number_____/____/____ Sex F ( ) M ( ) DOB___/__/__
Address_____
Phone Number_____ Employer_____
Patient Relationship to Responsible Party _____
Email Address_____

Primary Insurance Information

Name of Insured_____ Patient Relationship to the Insured_____
Insurance Company/Phone number_____ ( )_____
Subscriber ID_____ Group ID_____
Co-pay Amount_____
Effective Day_____ Termination Date_____ Sex F( ) M ( )
Insured DOB __/___/____ Insured's Social Security Number_____-_____-_____

Secondary Insurance Information

Name of Insured_____ Patient Relationship to the Insured_____
Subscriber ID_____ Insured DOB __/___/____

How did you Hear about us?

( ) Friend/Family (who)_____ ( ) El Paso Directory ( ) Website

( ) other

Emergency contact information:

Name:_____ Name:_____
Phone Number#_____ Phone Number:_____
Relationship:_____ Relationship:_____