



Welcome!

REGISTRATION FORM

****Please make sure Office Staff copies your insurance/ID Card****

Section I (Patient/Client Information) Date _____

Name: _____ Nickname: _____ Age _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip _____
 Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

The best number to contact me (or parent) is Home phone Work phone Cell phone
 Will you accept texts for appt reminders? Yes No Gender _____ Race _____

Check Appropriate Box: Minor Single Married Widowed Separated Divorced

If Student, Name of School _____ City/State _____ FT PT

Person to contact in case of emergency _____ Phone (_____) _____

Best days of the week and time of day that works best for you for appointments: _____
 Do you have other family members who are seen here? _____

Section II (Responsible Party – Spouse or Parent/Guardian info, if client is a child)

Relationship to Patient: Self Spouse Parent Other
 Name (Printed): _____
 Address (if different than above): _____
 City: _____ State: _____ Zip: _____ Phone: (____) _____
 Employer: _____ Work Phone: _____

Section III (Insurance Information):
 Please circle one:
 BCBS Aetna Medicare North Carolina Health Choice NC Medicaid Tricare Cash

Name of Insured/Sponsor: _____ DOB _____
 Relationship to Patient _____
 Name of Employer: _____ Work Phone: (____) _____
 Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ Group # _____ ID# _____

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you and/or your family members

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, YOU MUST COMPLETE THE FOLLOWING:

Insurance Company _____ Group # _____ ID# _____

YOU MUST inform us immediately if there are any insurance changes, or you may be responsible for payment!

Section IV (Allergies): Please list all known allergies client may have:

Section V (Additional Family members): If you'd like to make an appointment for additional family members, please list them below:

Name	Age	Insurance Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____