PLEASE PRINT **PATIENT REGISTRATION FORM** PLEASE PRINT

Patient Name: ____
Last First Middle Mr., Mrs., Ms

Address: ____
Florida Address if not Resident Year round

City: ________________ST: _____ ZP: ____ Home Phone: __________

Address: ____
Permanent Address if not Resident Year round

City: ________________ST: _____ ZP: ____ Home Phone: __________

Work Phone #: _____________Patient's Cell Phone ________________

E-Mail Address: _______________

Date of Birth: ___ / ___ / ____ Patient's Social Security # ____________

How long have you lived in Florida? ______________________________

Birth place ____

Highest Level of Education: _____________________________________

INSURANCE INFORMATION

PRIMARY Insurance Carrier: _______________ Phone #: ____________

ID #: _____________________________ Group # : ___________________

Name of Policy Holder: _______Sex: ___ Date of Birth: ___ / __ / _____

Policy Holders Address: ______________ Home Phone: _____________

Work Phone#: ____________ Policy Holder Employer: ______________

Employers Insurance Plan: Y / N

Relationship of Patient to Policy Holder: ____________________________
Self Husband Wife Child Other

SECONDARY Insurance Carrier: ____________ Phone: ______________

ID #: _______________________________ Group # : ____________________
Name of Policy Holder: ________Sex: ___ Date of Birth: ___ / __ / _____
Policy Holders Employer __________________ Work Phone: ___________
Policy Holders Address ___________________ Home Phone: ___________
Relationship to Patient: ____
Is this a Second Insurance through employer, retirement, or individual policy?

Is your visit today due to an WORKERS COMPENSATION CASE or AUTO ACCIDENT? Y N Date of injury: ___________________________________

Are you employed: Y N. Full Time Part Time Retired Student: FT PT
Position: ___________________
Employer or School Name and Address: ____________________________
____
Spouse or Emergency Contact Name: ______________________________
Spouce Social Secuirity #: ____
Work #: ____________ Cell Phone #: _________________________________
Who Referred You to our Office? ___________________________________

Any Known Drug Allergies? Y N If Yes What _________________________
Do you have a Latex Allergy? Y N
PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT
Do you have a Living Willing / Advance Medical Directive? Y N
Would you like to speak to a staff member about these items? Y N
Primary Language Spoken: English Spanish French Russian Creole
OTHER: ____
Name of your previous physician:___________________________________
Phone #: ____
Address: ____

Below is for Office Use Only

DATE INITIALS	DATE INITIALS	DATE INITIALS