PATIENT REGISTRATION FORM

Today's Date: _____ Clinic Name: ***THOC, P. A dba***

PATIENT INFORMATION: (Please use full legal name)

Last name: _____ First name: _____ Middle Initial: _____
Address: _____

City: _____ State: _____ Zip: _____
Home Phone # (_____) _____- _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Employer Name and Address: _____

Email Address: _____ Drivers Lic#_____
Emergency Contact Name: _____ Emerg Phone # (_____) _____ - _____

Referred by: _____ Please tell us how you heard about us: _____

GUARANTOR INFORMATION (List person or insured responsible for bill—use full legal name)

Relationship of Guarantor to Patient: Self☐ Spouse☐ Parent☐ Other☐
Last name: _____ First name: _____ Middle Initial: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone # (_____) _____- _____ Social Security #: _____
Date of Birth: _____ Age: _____Sex: M or F
Employer Name and Address: _____
Work Phone: (_____) _____ - _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:
Plan name: _____ Insured Name: _____
Insured's Social Security #_____ Insured's Date of Birth:_____
Policy/ ID #_____ Group #_____ Effective Date: _____
Claims Address & Phone: _____

SECONDARY INSURANCE:
Plan name: _____ Insured Name: _____
Insured's Social Security #_____ Insured's Date of Birth: _____
Policy/ ID #_____ Group #_____ Effective Date: _____
Claims Address & Phone: _____