900 New Hampshire Avenue, NW
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PATIENT REGISTRATION FORM

NAME- Last:_____ First:_____ Middle Initial: _____

ADDRESS – Street:_____ Apartment: _____

City:_____ State:_____ Zip Code:_____

DATE OF BIRTH:_____ MARITAL STATUS:_____ MALE/FEMALE:_____

SOCIAL SECURITY NO.:_____ EMAIL:_____

TELEPHONE (indicate preference): Home:_____ Work:_____ Mobile:_____

PREFERRED PHARMACY:_____ TELEPHONE NO.:_____

EMERGENCY CONTACT INFORMATION – Name:_____

Relationship:_____Telephone No.:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company:_____ Effective Date:_____

Insurance Company Address:_____

Name of Insured:_____ Relationship to Patient:_____

Policy Number:_____ Group Number:_____

SECONDARY INSURANCE

Insurance Company:_____ Effective Date:_____

Insurance Company Address:_____

Name of Insured:_____ Relationship to Patient:_____

Policy Number:_____ Group Number:_____

Patient or Responsible Party Authorization:

I, the undersigned, consent to medical examination or treatment for myself, or the minor child named above whose parent or guardian I am. I understand and agree that I am personally responsible for any charges at the time that services are rendered.

Patient/Guardian Signature:_____ **Date:**_____