PATIENT REGISTRATION / CONSENT

Acct. No:	Chart No:

PATIENT DATA	TODAY'S DATE:	SOCIAL SECURITY #: – –

PATIENT *(LAST)* *(FIRST)* *(MIDDLE)*	SEX ☐ M ☐ F	BIRTH DATE *Month* / *Day* / *Year*
ADDRESS (No.) (Street) *(City)* *(State)* *(Zip)*		PHONE *(Home)* ____ *(Work)*
EMAIL ADDRESS	EMPLOYER	

RESPONSIBLE AGENT (Who will pay for patient's services)

NAME *(LAST)* *(FIRST)* *(MIDDLE)*	RELATIONSHIP TO PATIENT ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER
BILLING ADDRESS *(No.)* *(Street)* *(City)* *(State)* *(Zip)*	PHONE *(Home)* ____ *(Work)*
PLACE OF EMPLOYMENT *(Name)* *(Address)*	PHONE NO. FOR MAKING APPOINTMENTS *Before 5:00 p.m.* ____ *After 5:00 p.m.*
	RESPONSIBLE AGENT'S SOCIAL SECURITY NUMBER

Who can we notify in case of emergency?

NAME *(LAST)* *(FIRST)*	RELATIONSHIP TO PATIENT
ADDRESS (No.) *(Street)* *(City)* *(State)*	PHONE NO. *Before 5:00 p.m.* ____ *After 5:00 p.m.*

____
Witness

____
Signature of patient or responsible agent

____
Date

____
If responsible agent, relationship to patient