

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
 ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 E-MAIL _____ CELL PHONE _____ HOME PHONE _____
 SS#/SIN _____ BIRTHDATE _____
 CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
 IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
 PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
 BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____
 PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
 ADDRESS _____ HOME PHONE _____
 DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
 EMPLOYER _____ WORK PHONE _____
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
 NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
 BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
 NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
 EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
 INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
 HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767/2700 COLWELL 1-800-637-1140

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR _____

PATIENT NUMBER _____

REGISTRATION