

Dr. _____ Appt: _____

PATIENT REGISTRATION

Acct# _____

PATIENT INFORMATION

1. Patient Name: _____
 (Last) (First) (Middle Initial) (Nickname)
2. Address: _____
 (City) (State) (Zip) Apt.# _____
3. Home Phone: () _____ 4. Work Phone: () _____ Ext.#: _____ Cell () _____
5. Soc.Sec #: _____ 6. Sex M F 7. Marital Status: S M D W 8. Birthdate: _____ Age: _____
9. Email: _____ Other Contact Numbers: _____
10. Employer: _____ Occupation: _____ 11. Student/School: _____ Full Time ___ Part Time ___
12. If dependent child, are custodial parents: Married _____ Separated _____ Divorced _____ Other _____
13. IN CASE OF EMERGENCY NOTIFY: Name _____ Relationship _____ Address _____
 _____ Phone () _____
14. Primary Care Physician: _____
 (Name) (Address) (Phone)
15. Pharmacy Name and Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

If same as patient, please complete only questions #1 & #6 of this section

1. Guarantor Name: _____ Birthdate: _____
 (Last) (First) (Middle Initial)
2. Guarantor Address: _____
 (City) (State) (Zip)
3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend Other
4. Home Phone: () _____ 5. Soc. Sec. #: _____ 6. Drivers License #: _____
7. Guarantor's Employer: _____ Work Phone () _____ Occupation _____
8. SPECIAL ARRANGEMENTS: _____

DO YOU HAVE INSURANCE*? ____ YES ____ NO (IF YES, PLEASE COMPLETE BELOW)

**Please note: Dr. Henderson does not routinely bill insurance but it is still helpful to have this information on file for future reference.*

1. **Primary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____
2. Subscriber's Name: _____ 3. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____
4. Birthdate: _____ 5. Group ID #: _____ 6. Soc. Sec. #: _____
7. **Secondary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____
8. Subscriber's Name: _____ 9. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____
10. Birthdate: _____ 11. Group ID #: _____ 12. Soc. Sec. #: _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Dr. Henderson:

Guarantor Signature (Patient signature, if patient is guarantor) _____ Date _____