TIME 5:03 PM DATE 10/5/2020

## **PATIENT REGISTRATION**

	ID:	Chart ID:				
Responsible Party (of someone other than the patient)   First Name	First Name:	Last Name:			Middle Initial:	
			Preferred Name:			
Address:	Responsible Party (if so	meone other than the patient)				
Cathon	First Name:		Last Name:			Middle Initial:
Birth Date:	Address:		Addre	ess 2:		
Birth Date:	City, State, Zip:				Pager: _	
O Responsible Party is also a Policy Holder for Patient   O Primary Insurance Policy Holder   O Secondary Insurance Policy Holder   Patient Information   Address 2:	Home Phone:	Work Phone	e:	Ext:	Cellular:_	
Patient Information   Address 2:	Birth Date:	Soc Sec	:	D	rivers Lic:	
State / Zip:	, ,	is also a Policy Holder for Patie	nt O Primary Insuranc	ce Policy Holder	O Secondary	Insurance Policy Holder
Note   Name   Name	Address:		Addre	ess 2:		
Note   Name   Name						
Birth Date:						
E-mail:	Sex: Male	○ Female	Marital Status:   Marr	ied O Singl	e Divorced	○ Separated ○ Widowed
Section 2	Birth Date: -	Age:	Soc. Sec:		Drivers Lic:	
Employment Status:	E-mail:		I wou	ıld like to receive	e correspondences vi	a e-mail.
FAMILY/SINGLE COV:	Section 2					
Student Status:	Employment Status: (	Full Time Part Time	Retired			· · · · · · · · · · · · · · · · · · ·
Medicaid ID:	Student Status:	ull Time Part Time				MAY/DANI.
Employer ID:	$\smile$		tiot.			
Employer ID:         Pref. Pharmacy:         COMPREHENSIVE EXAM:	Medicaid ID:	Pref. Der	ust:			
Carrier ID:         Pref. Hyg.:         ELIGIBLE PERIODIC EX:           Primary Insurance Information         Relationship to Insured:         Spouse Child Other           Insured Soc. Sec:         Insured Birth Date:         Spouse Child Other           Employer:         Insured Birth Date:         Address:           Address:         Address:         Address:           Address 2:         City, State, Zip:         City, State, Zip:           Rem. Benefits:         .00 Rem. Deduct:         .00           Secondary Insurance Information         Relationship to Insured:         Self Spouse Child Other           Insured Soc. Sec:         Insured Birth Date:         Address:           Employer:         Insured Birth Date:         Address:           Address:         Address:         Address:           Address:         Address:         Address:	Employer ID:	Pref. Pha	rmacy:			
Name of Insured:  Insured Soc. Sec:  Insured Birth Date:  Employer:  Address:  Address 2:  City, State, Zip:  Relationship to Insured: Self	Carrier ID:	Pref. Hyg	.:			
Insured Soc. Sec:	Primary Insurance Infor	mation				
Employer:       Ins. Company:         Address:       Address:         Address 2:       Address 2:         City,State,Zip:       City,State,Zip:         Rem. Benefits:       .00       Rem. Deduct:       .00         Secondary Insurance Information       Relationship to Insured:       Self       Spouse       Child       Other         Insured Soc. Sec:       Insured Birth Date:       Ins. Company:       Address:       Address:       Address:       Address:       Address:       Address:       Address:       City,State,Zip:       City,S	Name of Insured:			Relationship to I	nsured: Self	Spouse Child Other
Address:	Insured Soc. Sec:		Insured Birth Date:			
Address:	Employer:		lns	s. Company:		
Address 2: City,State,Zip: City,State,Zip: City,State,Zip: City,State,Zip: City,State,Zip: City,State,Zip: Ren. Benefits:00 Rem. Deduct:00  Secondary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date:						
City,State,Zip:         City,State,Zip:           Rem. Benefits:         .00         Rem. Deduct:         .00           Secondary Insurance Information         Relationship to Insured:         Self         Spouse         Child         Other           Insured Soc. Sec:         Insured Birth Date:         Ins. Company:         Address:         Address:         Address:         Address:         City,State,Zip:						
Rem. Benefits:						
Name of Insured:  Insured Soc. Sec:  Insured Birth Date:  Employer:  Address:  Address 2:  City,State,Zip:  City,State,Zip:						
Insured Soc. Sec:         Insured Birth Date:           Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City, State, Zip:         City, State, Zip:	Secondary Insurance In	formation				
Insured Soc. Sec:         Insured Birth Date:           Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City, State, Zip:         City, State, Zip:	Name of Insured:			Relationship to I	nsured: Self	Spouse Child Other
Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City, State, Zip:         City, State, Zip:						
Address 2:       Address 2:         City, State, Zip:       City, State, Zip:						
City,State,Zip: City,State,Zip:	Address:			Address:		
City,State,Zip: City,State,Zip:	Address 2:			Address 2:		