

# REGISTRATION FORM

Primary Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Have you ever seen Dr. Pletcher?  Yes  No Dr. Stouder?  Yes  No

## **Patient Information:**

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Gender:  Female  Male

May we contact you by email?  Yes  No If yes, email \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

## **Insurance Information:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Name: \_\_\_\_\_

Health Savings Account?  [Yes]  [No]

## **Spouse Information:** (if covered by his/her insurance as primary or secondary)

Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## **Guardian/Parent Information:** (if patient is a minor)

Name: Mother \_\_\_\_\_ Father \_\_\_\_\_

Social Security#: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_