FreeState
HEALTH & WELLNESS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

FIRST NAME LAST NAME

DOB SSN

ADDRESS

PHONE

Home ☐ Cell ☐ Work ☐ Ok to leave a voicemail? Yes ☐ No ☐ Ok to text message? Yes ☐ No ☐

EMAIL

RELATIONSHIP STATUS Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐

GENDER Female ☐ Male ☐ Other ☐

EMERGENCY CONTACT

NAME RELATIONSHIP TO PATIENT PHONE

INSURANCE INFORMATION

INSURANCE COMPANY ID NUMBER POLICY NUMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ID NUMBER POLICY NUMBER

FreeState
HEALTH & WELLNESS

PATIENT REGISTRATION FORM

POLICY HOLDER INFORMATION

FIRST NAME ____________________ LAST NAME ____________________

DOB ____________________ SSN ____________________

ADDRESS ____________________ PHONE ____________________

PARENT/GUARDIAN #1

NAME ____________________ DOB ____________________ GENDER Female ☐ Male ☐ Other ☐

RELATIONSHIP TO PATIENT ____________________ SSN ____________________

ADDRESS ____________________ PHONE ____________________

EMAIL ____________________

PARENT/GUARDIAN #2

NAME ____________________ DOB ____________________ GENDER Female ☐ Male ☐ Other ☐

RELATIONSHIP TO PATIENT ____________________ SSN ____________________

ADDRESS ____________________ PHONE ____________________

EMAIL ____________________