

Patient (or Responsible Party) Signature____

PATIENT REGISTRATION RESTORATIVE WELLNESS, LLC

Date___

PATIENT INFORMATION				(Please Print)	
☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐	Ms. ∏Sir				
Patient's Name (Last)		(MI)	Previous Name		
Address Line 1					
City, State ZIP					
Horne Phone C		Work Phone	Ext.		
Primary Care Provider (PCP)					
			E-Mail Address:		
	MM/DD/YYYY Sex				
Race American Indian or Alaska Native [-	
Ethnicity Hispanic or Latino	_	Declined			
Language ☐ English ☐ Spanish ☐ Marital Status ☐ Married ☐ Single	ndian Japanese C			ussian Other	
Social Security Number		Employer Name	e		
Employment Status 1-Full-Time	☐2-Part-Time ☐3-No	t Employed ☐4-Sel	f-Employed 5-Retired	d ☐6-Active Military	
Student Status F-Full-Time Student	☐P-Part-Time Student	□N-Not a Student			
Emergency Contact Last Name _		First N	lame		
Phone Number		Do you have a liv	ving will? ☐Yes ☐No		
Emergency Contact Relationship to Patient					
Address Line 1					
City, State					
Home Phone	Work Phone		Ext		
Referring Provider Name					
PRIMARY INSURANCE INFORMAT	ΓΙΟΝ	(provide yo	ur insurance card to the f	ront desk at check-in)	
Insurance Company/Phone Number					
Name of Insured		Patient Relationship to Insured			
Subscriber ID (Policy Number)	Gi	oup ID	Copay Amour	nt	
Effective Date	Termination Date	Da	te of Birth MM/DD	/YYYY	
SECONDARY INSURANCE INFOR	MATION	(provide yo	ur insurance card to the f	ront desk at check-in)	
Insurance Company/Phone Number					
lame of Insured		Patient Relationship to Insured			
Subscriber ID (Policy Number)	G	oup ID	Copay Amour	nt	
Effective Date	Termination Date	Da	te of Birth MM/DD	/YYYY	
I agree that the information supplied on t	his form is accurate and	up-to-date to the best o	of my knowledge.		