PATIENT REGISTRATION FORM

PLEASE PRINT

Today's Date_____

Name_____

Address_____Phone ( ) _____Home

City_____State_____Zip_____( )_____ Work

Email address _____Cell Phone ( ) _____

*Note: Your email will not be shared with any 3rd parties, and is only used for occasional office announcements.

Driver's License#_____State_____

Birth date_____Age_____Sex: (Circle one) Male Female

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Employer_____Occupation_____

Address_____City_____State_____Zip_____

Employer's Phone number_____

Employer's Email address (if known)_____

Are you driving now? (Circle one) Yes No If Yes (Circle one): Interstate Local Both

If yes, what type of vehicle are you driving?_____

If driving now, how long have you been driving?_____ Months Years (Circle one)

Student? (Circle one) Yes or No Are you a (Circle one): CDL Applicant or Holder

Referred by: (How did you hear about us)?_____

FEES ARE PAYABLE WHEN SERVICE IS RENDERED-PAYMENT METHODS INCLUDE CASH OR CHARGE. INSURANCE IS NOT ACCEPTED FOR DOT PHYSICALS. WE DO NOT BILL INSURANCE FOR OTHER SERVICES RENDERED IN THIS OFFICE. IF YOU DO HAVE INSURANCE, WE WILL GLADLY GIVE YOU AN ITEMIZED STATEMENT TO PRESENT TO YOUR INSURANCE COMPANY. THANK YOU FOR CHOOSING OUR OFFICE!