# PATIENT INFORMATION

**Account # ______________________**

**Last Name:** ______________________ **First:** ______________________ **MI:** __________

**Date of Birth:** ______________________ **Social Security#:** ______-________-_________

**Mailing Address:** ______________________ **City:** ______________________ **State/Zip** __________

**Home Phone:** ______________________ **Work:** ______________________ **Cell:** ______________________

**Email address:** ______________________________________________

**Employer:** ______________________________________________
**Name** **Address** **Zip** **Phone**

**Spouse's Name:** ______________________ **Spouse's Date of Birth:** ______________________

**Spouse's Social Security#:** ______-_______-______ **(for insurance purposes only) Spouse's Cell:** ______________________

**Emergency Contact (Name of friend or relative NOT living with you):** **Name** ______________________

**Phone** ______________________ **Relationship to Patient:** ______________________

**Referring Physician:** ______________________________________________

**Primary Care Physician:** (if different from above) ______________________________________________

## INSURANCE INFORMATION

**Medicare#:** ______________________ **(Part A or B or Both) Medicaid#:** ______________________

**Community Care Physician (Medicaid Only-if applicable):** ______________________
**Phone:** ______________________

**Primary Insurance:** ______________________________________________
**Name** **Address** **Zip** **Phone**
**Primary Insured:** ______________________ **Relationship to Insured:** ______________________

**Policy #:** ______________________ **Group#:** ______________________

**Employer:** ______________________________________________
**Name** **Address** **Zip** **Phone**

**Secondary Insurance:** ______________________________________________
**Name** **Address** **Zip** **Phone**
**Primary Insured:** ______________________ **Relationship to Insured:** ______________________

**Policy #:** ______________________ **Group#:** ______________________

**Employer:** ______________________________________________
**Name** **Address** **Zip** **Phone**

**I have read all the information on these registration sheets and have answered all questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance and the registration information.**

**Patient Signature:** ______________________ **Date:** ______________________
**If patient is a minor or unable to sign:**

**Patient Representative:** ______________________ **Relationship to Patient:** __________________

TVC08192014