Forever Young
HEALTH & WELLNESS

PATIENT REGISTRATION FORM

Today's Date:_____How did you hear about our clinic?_____

Last Name_____ First Name_____ M Initial_____

Address_____City/St/Zip_____

Date of Birth _____ SS #_____ Employer_____

Do you have a living will? ◯ Yes ◯ No

Phone Options	Phone Number	Ok to leave detailed message?	Call this number (select one)
Home #		◯ Yes ◯ No	◯ 1st ◯ 2nd ◯ 3rd choice
Cell #		◯ Yes ◯ No	◯ 1st ◯ 2nd ◯ 3rd choice

Would you like to communicate by email? ◯ No ◯ Yes:_____
Do you prefer that we email or call you first? ◯ Email ◯ Call *(at the numbers listed above)*

EMERGENCY CONTACT

Name_____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ Insured ID#_____

Address (see back of card)_____Group#_____

City/St/Zip _____ Phone_____

Policy Owner_____ Insured Date of Birth _____

Patient Relationship to Policy Owner _____

POLICY HOLDER INFORMATION (if different then yourself)

Last Name_____ First Name_____ M Initial_____

Address_____

City/St/Zip _____ Date of Birth_____SS #_____

Home Phone_____Cell _____

Employer_____ Work Phone _____

Work Address_____ City/State/Zip _____

SECONDARY INSURANCE_____ Insured ID#_____

Address_____ Group# _____

City/St/Zip _____ Phone_____

Policy Owner_____ Insured Date of Birth _____

Patient Relationship to Policy Owner _____