School of Allied Health Professions
Patient Registration/Update

☐ New Patient ☐ Update

Last Name _____ First Name _____ Middle Name _____

☐ Female ☐ Male ____/____/____ Date of Birth ____-____-____ Social Security Number

Patient's Street Address _____ City _____ State _____ Zip _____ (____) Phone Number _____

Responsible Person's Name _____ Relationship to Patient _____ E-mail address _____

Responsible Person's Address _____ City _____ State _____ Zip _____ (____) Phone Number _____

____/____/____ Responsible Person's Date of Birth ____-____-____ Responsible Person's Social Security Number

Emergency Contact Name _____ Relationship _____ (____) Phone Number _____

Primary Insurance

Insurance Company Name _____ Contract/Certificate # _____ Policy or Group # _____

Insurance Company Address _____ City _____ State _____ Zip _____ (____) Phone Number _____

Relationship to Subscriber _____ Subscriber Name _____ Subscriber Social Security # _____

Subscriber's Employer _____ (____) Employer's Phone Number _____

Secondary Insurance

Insurance Company Name _____ Contract/Certificate # _____ Policy or Group # _____

Insurance Company Address _____ City _____ State _____ Zip _____ (____) Phone Number _____

Relationship to Subscriber _____ Subscriber Name _____ Subscriber Social Security # _____

Subscriber's Employer _____ (____) Employer's Phone Number _____

For Office Use Only

Appointment Date: _____ Account #: _____

Clinician: _____ Referring Provider: _____