Epps Medical Associates

REGISTRATION FORM

Section I: **Patient Information** **Date**______________

Name:____ I Prefer to be called: ____________________
Address:_____________________________________City:______________State:_________Zip____________
Home(________)__________________Work(_______) _______________Cell (________)__________________
The best time to contact me is:_______________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:______________ Social Security Number:______________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School__________________________ City/State_________________________ ☐ FT ☐ PT
Spouse or Parent's Name:___________________________ Employer_________________ Work Phone__________
Whom may we thank for referring you? ____
Person to contact in case of emergency________________________________ Phone______________________
Email Address____________________________________ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ___________________
Address:____
City:____________________________ State:_________ Zip:__________ Phone: (___)___________________
Employer______________________ Work Phone (___)________________ SSN#__________________________

Section III **Insurance Information**

Name of Insured______________________________DOB_____________Relationship to Patient ____________
SSN#:______________________ Name of Employer:____________________ Work Phone: (___)______________
Address of Employer:_________________________________City_______________State:_______Zip _________
Insurance Company__________ __________________Grp #____________________ ID#_____________________
Ins Co Address:____ Ins Co. Phone:_________________________

——— DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ———

Name of Insured______________________________DOB_____________Relationship to Patient ____________
SSN#:______________________ Name of Employer:____________________ Work Phone: (___)______________
Address of Employer:_________________________________City_______________State:_______Zip _________
Insurance Company_____________________________Grp #____________________ ID#_____________________
Ins Co Address:____ Ins Co. Phone:_________________________