



Today's date: \_\_\_\_\_

# REGISTRATION FORM

(Please Print)

Check here if you DO NOT want us to mail your biopsy results to you

## PATIENT INFORMATION

|  |  |                          |        |  |   |
|--|--|--------------------------|--------|--|---|
| Patient's last name:   |  | First:                   | M. I.: | Marital status (circle one):                                     |   |
|  |  |                          |        | Minor / Single / Mar / Sep / Div / Wid / Partnered / for:    yrs |   |
| Email address (please provide only if it's OK to email you appointment reminders):   |  |                          |        | Birthdate:   | Age:  |
|  |  |                          |        | / /  | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Address:   |  | Home phone no.:          |        | Cell phone no.:  |   |
|  |  | (    )                   |        | (    ) <input type="checkbox"/> OK to text                       |   |
| City:  |  | State:                   |        | ZIP Code:  | Social Security no.:  |
|  |  |                          |        |  |   |
| Occupation:  |  | Employer/School:         |        | Employer/School phone no.:                                       |   |
|  |  |                          |        | (    )   |   |
| Employer's Address:  |  | City:                    |        | State:   | ZIP Code:   |
|  |  |                          |        |  |   |
| Spouse's name:   |  | Spouse's work phone no.: |        | Spouse's cell phone  | Spouse's Social Security no.:                                 |
|  |  | (    )                   |        | (    )   |   |
| How did you get our phone number? <input type="checkbox"/> Phone book <input type="checkbox"/> Internet <input type="checkbox"/> Other:  |  |                          |        |  |   |
| Selected our office the first time because / Referred to office by (check all that apply): <input type="checkbox"/> Another medical office or provider <input type="checkbox"/> Insurance Plan   |  |                          |        |  |   |
| <input type="checkbox"/> NPR radio <input type="checkbox"/> Website/Online <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Live or work nearby <input type="checkbox"/> Saw your building or sign <input type="checkbox"/> Postcard <input type="checkbox"/> Newsletter |  |                          |        |  |   |
| <input type="checkbox"/> Another patient/word of mouth <input type="checkbox"/> Chamber of Commerce <input type="checkbox"/> Google <input type="checkbox"/> Facebook <input type="checkbox"/> Other:  |  |                          |        |  |   |

## IN CASE OF EMERGENCY

|  |                          |                      |                 |
|--|--------------------------|----------------------|-----------------|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Cell/home phone no.: | Work phone no.: |
|  |                          | (    )               | (    )          |

## GUARANTOR INFORMATION (fill out if person responsible for bill is different than patient)

|                         |           |                 |                      |
|-------------------------|-----------|-----------------|----------------------|
| Guarantor's last name:  | First:    | Middle initial: | Birthdate:           |
|                         |           |                 | / /                  |
| Address (if different): | City:     |                 | State:               |
|                         |           |                 | ZIP Code:            |
| Occupation:             | Employer: |                 | Social Security no.: |
|                         |           |                 | (    )               |

## PARENTS OF MINOR

|                     |        |        |                     |        |        |
|---------------------|--------|--------|---------------------|--------|--------|
| Mother's last name: | First: | M. I.: | Father's last name: | First: | M. I.: |
|                     |        |        |                     |        |        |

## INSURANCE INFORMATION

|  |                         |                        |                            |
|--|-------------------------|------------------------|----------------------------|
| Insurance Company:   | Subscriber's FULL name: | Subscriber ID no.:     | Group no. (if applicable): |
|  |                         |                        |                            |
| Patient's relationship to subscriber:<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | Subscriber's Employer:  | Subscriber's S.S. no.: | Birthdate:                 |
|  |                         |                        | / /                        |

## SECONDARY INSURANCE

|   |                         |                        |                            |
|---|-------------------------|------------------------|----------------------------|
| Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "YES," this section <b>MUST</b> be <b>COMPLETELY</b> filled out. |                         |                        |                            |
| Insurance Company:  | Subscriber's FULL name: | Subscriber ID no.:     | Group no. (if applicable): |
|   |                         |                        |                            |
| Patient's relationship to subscriber:<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other        | Subscriber's Employer:  | Subscriber's S.S. no.: | Birthdate:                 |
|   |                         |                        | / /                        |

## MEDICARE ONLY

|   |   |
|---|---|
| Does patient live in a skilled nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is patient currently under hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |   |