

PATIENT REGISTRATION

LAST NAME		FIRST NAME		MIDDLE INIT	SEX M or F
STREET ADDRESS			CITY	STATE	ZIP
DATE OF BIRTH	SSN	MARITAL STATUS S M D W SEP	EMAIL ADDRESS		
CELL PHONE #	HOME PHONE #	WORK PHONE #	SPOUSE'S NAME		
EMPLOYER NAME (circle F/T or P/T)			OCCUPATION		
ARE YOU BEING SEEN FOR AN ACCIDENT-RELATED INJURY: Y or N				DATE OF INJURY	
IF SO, PLEASE COMPLETE ADDITIONAL FORM AT OFFICE VISIT					

IF PATIENT IS 18 OR UNDER, PLEASE COMPLETE:

FATHER'S FULL NAME	CELL PHONE #	WORK PHONE #
MOTHER'S FULL NAME	CELL PHONE #	WORK PHONE #

INSURANCE INFORMATION (In addition to listing all insurance plans, please present your card so that we may copy.)

PRIMARY INSURANCE	TELEPHONE #	MEMBER ID #	GROUP #
INSURED'S NAME	DATE OF BIRTH	EMPLOYER NAME (F/T or P/T)	RELATIONSHIP TO PT
SECONDARY INSURANCE	TELEPHONE #	MEMBER ID #	GROUP #
INSURED'S NAME	DATE OF BIRTH	EMPLOYER NAME (F/T or P/T)	RELATIONSHIP TO PT

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT? If patient is the responsible party, check here

RESPONSIBLE PARTY NAME	ADDRESS		
EMPLOYER	WORK PHONE #	CELL PHONE #	SSN

EMERGENCY CONTACT PERSON (NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU)

CONTACT'S NAME	TELEPHONE #	RELATIONSHIP TO PT
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WHOM MAY WE THANK FOR REFERRING YOU TO DR COPELAND? (PLEASE BE SPECIFIC)

Physician _____
 Friend/Patient _____
 Yellow Pages Newspaper/Magazine _____ Other _____
 Internet (please specify search engine) _____

CONSENT TO TREATMENT: I HEREBY CONSENT TO MEDICAL TREATMENT RENDERED BY JEFFREY COPELAND, M.D.

SIGNATURE _____ DATE _____
 (If Minor, Parent or Legal Guardian Must Sign)