Registration Form

Fax application to: (702) 272-2011 Questions? Call: (844) 262-7223

DATE:	FORM COMPLETED BY:	
SECTION I: PATIENT INFORMATION		
NAME (LAST, FIRST, MI):		GENDER: ☐ M ☐ F
DOB (MM/DD/YYYY):	SSN:	MEDICAID ID:
ADDRESS:		
CITY:	STATE:	ZIP:
PRIMARY PHONE:	WORK PHONE:	
EMAIL ADDRESS:		
CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED		
IF STUDENT, NAME OF SCHOOL:		
WHOM MAY WE THANK FOR REFERING YOU?		
PERSON TO CONTACT IN CASE OF EMERGENCY:		PHONE:
SECTION II: RESPONSIBLE PARTY INFORMATION		
NAME (LAST, FIRST, MI):		RELATIONSHIP TO PATIENT:
ADDRESS:		
CITY:	STATE:	ZIP:
PRIMARY PHONE:	WORK PHONE:	
SSN:	EMPLOYER:	
SECTION III: INSURANCE INFORMATION		
NAME OF INSURED:	RELATIONSHIP TO PATIENT:	
DOB:	SSN:	
NAME OF EMPLOYER:	WORK PHONE:	
ADDRESS OF EMPLOYER:		
CITY:	STATE:	ZIP:
INSURANCE COMPANY:	ID #:	GROUP #:
INSURANCE COMPANY ADDRESS:		
INSURANCE COMPANY PHONE:		
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ NO ☐ YES IF YES, COMPLETE THE FOLLOWING:		