Washington Homeopathic Clinic

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Patient Registration Form

TODAY'S DATE _____

PATIENT INFORMATION

First Name _____ **Last Name** _____

Date of Birth _____ **Gender** _____

Address _____

City _____

State _____ **Zip** _____

Cell Phone _____ **Home Phone** _____

Email Address _____

Marital Status (Needed for insurance) _____

Parent/Guardian Name(s) _____

_____

INSURANCE

Primary Insurance Company Name _____

ID Number _____ **Group Number** _____

Subscriber Name _____ **Subscriber Date of Birth** _____

PAYMENT (person responsible for payments, if other than patient)

Name _____ **Relationship** _____

Email Address _____

EMERGENCY CONTACT

Name _____ **Phone** _____

Relationship to Patient _____