DR. ROBERT PETERSON

Patient Registration (Insurance)

Please fill in all blanks

Marital Status: **Single** **Divorced** **Married** **Widowed**

Mr. **Mrs.** **Ms.** **Miss** **Dr.** Patient's Name _____

Address _____ Email _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Primary Care Dr. _____ Office Number _____

Social Security # _____ Date of Birth _____

Patient's Employer _____

How did you hear about us?

Friend/Family _____ Internet Insurance Magazine _____

Doctor _____ Existing Patient _____ Other _____

Spouce Information:

Spouse _____ Spouse Contact _____

Spouse DOB _____ Spouse SSN _____

Spouse Employer _____ Work _____

Insurance Information:

Primary _____ ID/SSN _____

Subscriber _____ Group or Poilicy No. _____

Secondary _____ ID/SSN _____

Subsciber _____ Group or Poilicy No. _____

DOB _____ Sex **M** **F**

** If non-payment by insurance in (60) days, patients are responsible for unpaid fees.*

SIGNATURE _____ DATE _____