



# Patient Registration Form

Please print when completing this form. As a reminder, all information is confidential.

Today's Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Marital Status:  Married  Single

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  Divorced  Separated

Email: \_\_\_\_\_  Widow  Partner

May we send you information by e-mail?  Yes  No

For privacy purposes how do you prefer to be contacted

Home Phone  Cell Phone  
 E-Mail  Text Message  
 Work Phone

Patient or Parent's Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

If patient is a student, name of school/college: \_\_\_\_\_

How were you referred to us: Please check all that apply

Internet: \_\_\_\_\_ Station: \_\_\_\_\_  
 Google \_\_\_\_\_ Patient Name of Patient: \_\_\_\_\_  
 Docshop \_\_\_\_\_ Doctor Name of Doctor: \_\_\_\_\_  
 Other internet \_\_\_\_\_ What internet site or search engine? \_\_\_\_\_  
 Word of Mouth \_\_\_\_\_ please circle: friend, relative, employee, hospital staff  
 Sign on Building \_\_\_\_\_ Magazine Name of magazine: \_\_\_\_\_  
 Yellow pages \_\_\_\_\_ Other Name of other source: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party Information

Person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Driver's License Number \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is this person currently a patient at our office?  
 Yes  No

Insurance Information

Name of insurance company: \_\_\_\_\_ (A copy of card will be made)

Policyholder's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Notice of Privacy Practice I consent for Dr. Jeffrey Ditesheim to use and disclose protected health information for treatment, payment and healthcare operations. I have ready a copy of Dr. Ditesheim's Notice of Privacy Practices (HIPAA) and consent to all disclosures.

Patient or Legal Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_