

EAGLE HEALTH & WELLNESS

PATIENT/CLIENT REGISTRATION

CHART ID# _____

DATE: ____/____/____

Patient/Client Information

First Name: _____ Last Name _____ Middle Intl: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext _____ Cell Phone (____) _____

Birth Date: ____/____/____ Sex: Male _____ Female _____ Social Security # _____

Marital Status: (circle one) Married Single Divorced Separated Widowed

E-mail: _____ Emergency Contact Name _____ Ph # (____) _____

Responsible Party (if other than Patient/Client)

Referred by: _____

First Name: _____ Last Name _____ Middle Intl: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext _____ Cell Phone: (____) _____

Birth Date: ____/____/____ Sex: Male _____ Female _____ Social Security # _____

Marital Status: (circle one) Married Single Divorced Separated Widowed

E-mail: _____

Responsible Party is also a Policy Holder for Patient (Y) _____ (N) _____

Primary Insurance Information:

Secondary Insurance Information:

Name of Insured: _____

Name of Insured: _____

Relationship to Insured: Self _____ Spouse _____ Child _____

Relationship to Insured: Self _____ Spouse _____ Child _____

Employer: _____

Employer: _____

Phone # (____) _____

Phone # (____) _____

Insurance Co. _____

Insurance Co. _____

Address: _____

Address: _____

City, State and Zip: _____

City, State and Zip: _____

Phone # (____) _____

Phone # (____) _____

Insurance ID # _____ Group # _____

Insurance ID # _____ Group # _____