

# C2 Your Health, PC

REGISTRATION FORM: please mark spaces N/A if they do not apply

Section I:	Patient Information	Date _____
Name: _____		
Seeking evaluation for _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____		
Other Parent's Name: _____ Phone (____) _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Patient: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	

Section III	Insurance Information
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	