

**HEALTHQUEST PATIENT REGISTRATION**

If this is an employee assistance plan, you are required to contact the EAP office prior to visiting our office. Did you contact the EAP office?      YES                      NO

THE DOCTOR YOU ARE HERE TO SEE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ M/F      SOCIAL SECURITY NO. \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_                      DRIVERS LICENSE NO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_                      ST: \_\_\_\_\_                      ZIP: \_\_\_\_\_

HOME PHONE NO: (\_\_\_\_) \_\_\_\_\_                      WORK NO: (\_\_\_\_) \_\_\_\_\_

EMERGENCY NO: (\_\_\_\_) \_\_\_\_\_                      EMERGENCY PERSON: \_\_\_\_\_

MARITAL STATUS:      SINGLE                      MARRIED                      DIVORCED                      WIDOW

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

EMPLOYER TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_

SPOUSE: \_\_\_\_\_                      SSN for SPOUSE \_\_\_\_\_

FAMILY MEMBER'S TELEPHONE NUMBER AND ADDRESS NOT LIVING WITH YOU \_\_\_\_\_

RESPONSIBLE PARTY

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_                      RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_                      ST: \_\_\_\_\_                      ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_                      SSN: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS OF EMPLOYER: \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY CARRIER: \_\_\_\_\_                      POLICY OR ID NO: \_\_\_\_\_

INSURED OR SUBSCRIBER: \_\_\_\_\_                      D.O.B.: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_                      EFFECTIVE DATE: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_                      POLICY OR ID NO: \_\_\_\_\_

INSURED OR SUBSCRIBER: \_\_\_\_\_                      D.O.B.: \_\_\_\_\_

GROUP NO: \_\_\_\_\_                      EFFECTIVE DATE: \_\_\_\_\_