

Appt. Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_\_

Acct. # \_\_\_\_\_

# CHRISTOPHER R. HUBBELL, M.D.

## Patient Registration Form

### How did you hear about us?

- Phone Book     Seminar     Website/Internet  
 FACE/008 Magazine     Friend/Family(Name) \_\_\_\_\_  
 Doctor \_\_\_\_\_     Other (Specify) \_\_\_\_\_

Patient Name \_\_\_\_\_  Jr.  Sr. \*EMAIL \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex  M  F

Ph: \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ Alt Ph: \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ SSN# \_\_\_\_\_

Address \_\_\_\_\_  
Street # \_\_\_\_\_ Street Name \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient Employer \_\_\_\_\_ Phone Number \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### \*\*PATIENT OR GUARDIAN INFORMATION IF PATIENT IS MINOR\*\*

Name \_\_\_\_\_ # Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### To whom do you give our office permission to discuss your medical and financial information with?

Name: \_\_\_\_\_  DO NOT GIVE ANYONE MY INFORMATION

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

### \*\*INSURANCE INFORMATION\*\*

Primary Insurance Carrier Name: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Policyholder Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policyholder Date of Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Secondary Insurance Carrier Name: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Policyholder Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policyholder Date of Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PLEASE FILL OUT THE FORM COMPLETELY AND BRING WITH YOU AT THE TIME OF YOUR APPOINTMENT!  
PLEASE PRESENT INSURANCE CARDS & PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.**