

PATIENT REGISTRATION FORM**DATE:** _____**Richard Bingham, M.D & Julie Evans Bingham, Ph.D.**

PATIENT NAME		GENDER	M	F	DOB
Street		City			
State	Zip Code	Phone			
Mother's Name		Address (if different)			
Mother's Employer	Occupation			Home Phone Work Phone	
Father's Name		Address (if different)			
Father's Employer	Occupation			Home Phone Work Phone	
Step Parent's Name		Address (if different)			
Step Parent's Employer	Occupation			Home Phone Work Phone	
If Parents Divorced, Describe Custody Status					
Identify the Adults with Whom the Child Lives Parents Other (please explain)					
In case of an emergency, who do we notify (other than parents) Name:					
Relation to Patient		Home Phone		Work Phone	
Patient's Marital Status: Married Single Divorced Spouse's Name:					
Referred by					

INSURANCE INFORMATION

Responsible Party Bill Account To:		Relation To Patient			
Address (if different)		Phone			
Primary Insurance Company	ID#	Group #			
Insurance Company Address		Phone			
Policy Holder's Name		Policy Holder's Employer			