ChEARS Registration Form

PATIENT INFORMATION

Patient's Legal: _____ _____ _____
(*First Name*) (*Mi*) (*Last Name*)

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Rev ☐ Father ☐ Other _____

Birth Date: _____/_____/_____ **SSN** ___ ___ ___-___ ___-___ ___ ___ ___ **Sex**: ☐ Female ☐ Male
Mo DD YYYY

_____ _____,_____ _____
Home Address **City** **ST** **Zip**

Email Address: _____ **Home Phone #** : __ __ __ / __ __ __ / __ __ __ __

Work Phone # :__ __ __ / __ __ __ /__ __ __ __ **Cell Phone** # __ __ __ / __ __ __ / __ __ __ __

Alternate Contact: _____ **Relationship to Patient** _____

Alt. Add: _____ **Alt. Ph#:** __ __ __ / __ __ __ / __ __ __ __

REFERRAL SOURCE:_____

PRIMARY PHYSICIAN

Physician Name: _____ **Phone #**: __ __ __ / __ __ __ / __ __ __ __

Address: _____ **Fax #**: __ __ __ / __ __ __ / __ __ __ __

City, St, Zip _____ ,_____, _____

INSURANCE INFORMATION

Primary Ins: _____

Policy #: _____

Group # _____

_____
Subscriber's Name if other than self

_____
Subscriber's Address if other than self

_____
Subscriber's SSN if other than self

_____
Subscriber's DOB if other than self

_____
Patient's relationship to subscriber

Secondary Ins: _____

Policy #: _____

Group #: _____

_____
Subscriber's Name if other than self

_____
Subscriber's Address if other than self

_____
Subscriber's SSN if other than self

_____
Subscriber's DOB if other than self

_____
Patient's relationship to subscriber