Andrea Stebel, M.D. **Date: _____**

PATIENT REGISTRATION INFORMATION
Please PRINT and complete ALL sections below

Name:_____ _____
LAST FIRST INITIAL

Marital Status _____ **single** _____ **married** _____ **divorced** _____ **widowed** **M**___ **F**____

Street Address: _____ **Apt #** _____

City: _____ **State** _____ **Zip Code** _____

Home phone ( ) _____ **Work phone ( )** _____ **Ext:** _____

Cell Phone ( ) _____ **Date of Birth** _____/_____/_____

Social Security No. _____ **Driver's License No:** _____ **State** _____

How do you wish to be addressed? _____

Employer _____ **Occupation** _____ **Part-time** _____ **Full-time** _____

Address: _____ **City** _____ **State** _____ **Zip**_____

Please complete the following information if you are married or have insurance in another's name:

Spouse's Name: _____ **Date of Birth** _____/_____/_____

Spouse's Social Security Number: _____ **Employer** _____

Work Address: _____ **City** _____ **State** _____

Work Phone( ) _____

PRIMARY Insurance Company's Name _____ **Phone no.( )** _____

Insurance address _____ **City** _____ **State** _____ **Zip** _____

Name of Insured _____ **Relationship to Insured** _____

ID No. _____ **Group No.** _____

SECONDARY Insurance Company's Name _____ **Phone No.( )** _____

Insurance Address _____ **City** _____ **State** _____ **Zip** _____

Name of Insured _____ **Relationship to insured** _____

ID No. _____ **Group No.** _____

Referred By: _____ **Phone No. ( )**_____

Primary Care Physician: _____ **Other Physicians** _____

EMERGENCY INFORMATION:

Name of Person not Living with You: _____ **Relationship:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone number (Home) ( ) _____ **Work ( )** _____

Date: _____ **I attest the above to be true** _____
Patient signature

The above has been filled out for the patient by _____ _____
Print Name Signature