THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex M☐ F☐

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Marital Status _____ E-mail Address _____

Mailing Address _____ City _____

State _____ Zip Code _____

Physical Address _____ City _____

State _____ Zip Code _____

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Would you like us to share your visit notes with your PCP/Referring Provider? Y☐ N☐

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you hear about us?

Family/Friend☐ Website/Social Media☐ TV/Print Ad☐ Past Patient☐ Other☐ _____

Medical Professional Referral☐ Name: _____

Is this a work-related injury? Y☐ N☐

PRIMARY INSURANCE : _____ Member ID_____ Group #_____

POLICY HOLDER NAME _____ DOB _____ Relationship_____

SECONDARY INSURANCE: _____Member ID_____ Group #_____

POLICY HOLDER NAME _____ DOB _____ Relationship_____

OTHER: _____