

Dr. Brian K. Howard, M.D.
Patient Registration

Today's Date: _____

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: M F
Social Security #: _____ Driver's License #: _____
Home Address: _____ City/State: _____ Zip: _____
Mailing Address (if different): _____ E-Mail Address: _____
Home Telephone: () _____ Work Telephone: () _____
Occupation: _____ Employer's Name: _____
Employer's Address: _____ City/State: _____ Zip: _____

Spouse's Name: _____ Address: _____
Employer's Name & Address: _____
Home Telephone: () _____ Work Telephone: () _____

Parent if Patient is a Minor: _____ Date of Birth: _____ Age: _____
Social Security #: _____ Driver's License #: _____
Home Address: _____ City/State: _____
Mailing Address (if different): _____
Home Telephone: () _____ Work Telephone: () _____
Occupation: _____ Employer's Name: _____
Employer's Address: _____ City/State: _____ Zip: _____
Does the child live with both parents? YES _____ NO _____

Notify in Case of Emergency: _____ Relationship: _____
Home Telephone: () _____ Work Telephone: () _____

Nearest Relative (Not living with you): _____ Relationship: _____
Home Telephone: () _____ Work Telephone: () _____

Whom May We Thank for Referring You to Our Practice? _____

Financial Information (Person responsible for fees)

Name: _____ Relationship: _____ DOB: _____
Address: _____ City/State: _____

Primary Insurance

Insurance Company: _____ Subscriber Name: _____
Subscriber's Social Security #: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____ Subscriber Name: _____
Subscriber's Social Security #: _____ Relationship to Patient: _____
Were you injured on the job? Yes _____ NO _____ Have you informed your employer? Yes _____ NO _____