ADVANCED WELLNESS
61 Beaver Brook Road, Suite 103, Lincoln Park, NJ 07035

PATIENT REGISTRATION FORM

Date:	Patient's Last Name, First Name, & Middle Initial:	Date of Birth:	Age:	Patient Sex: __F __M	Social Security:
Patient Address:		Town:	State:	Zip Code:	
Primary phone #: __ cell __home __work	Secondary phone #: __ cell __home __work	Would you like to receive texts from us? ___Yes ___No	Who is your carrier?		
Email:	Emergency contact:	Relationship to Patient:	Phone #:		
Patient is: __ Single ___Married __ Separated __ Divorced __ Widowed __Other	Height: ____ ft ____ inches Weight: _____ lbs				
Do You Smoke: __every day __some days __ never __former					
Primary Language: __ English __ Spanish Other:_____	Ethnicity: ____ Hispanic Or Latino ____Not Hispanic Or Latino ____ Not Provided				
Race: ____American Indian Or Alaska Native ____ Asian ____ Black Or African American ____ White ____ Native Hawaiian Or Other Pacific Islander ____ Hispanic Or Latino Other:_____					
Consent For Our Office To Review Your Current Medications (circle one) Yes No					

INSURANCE INFORMATION - *This Section Must Be Completed*

Do You Have Health Insurance: ____ Yes ____ No If so, Name of Primary Insurance:	Do You Have Secondary Health Insurance? ___Yes ___No If so, Name of Secondary Insurance:
If You Are Not The Insured, Name Of Insured:	Relationship to Insured: Date Of Birth:

FOR NEW PATIENTS ONLY

How Did You Hear About Our Office?:	
Name of Referring Physician:	Address and Telephone #:

FOR AUTO AND JOB RELATED INJURIES ONLY

If injury is auto or job related: Name of person who can authorize treatment and phone #:		
Company's Insurance Carrier & Address (If auto related, please list Auto Insurance Information):		
Insurance Carrier Claim #:	Adjuster's Name:	Adjuster's Phone #:

Patient/Guardian's Signature: _____Date: _____