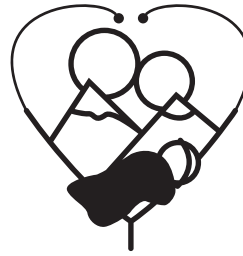


# ADULT PATIENT REGISTRATION

(Please Print)



**MICHAEL J. O'NEILL M.D., PLLC.**

1465 Kelly Johnson Blvd. Suite 310  
Colorado Springs, CO 80920

**Phone:** 719-419-7490

**Fax:** 719-309-6847

Date: \_\_\_\_\_

PATIENT: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male

Female

SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

## ***Emergency Contact Information***

Dependent? \_\_\_\_\_ If yes, Guardian's Name: \_\_\_\_\_

Guardian's Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

## ***Insurance***

Name of Insured/Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_