



REGISTRATION FORM

Please bring to your appointment:

2955 Triverton Pike Drive

Madison, WI 53711

608.227.7007 * 608.227.7027 (f)

PATIENT INFORMATION

Full Legal Name: Last _____ First _____ M _____

Address: Street/Box _____ Apt # _____

City _____ State _____ Zip _____

Best Contact Number - Please Check One:

Home # (____) ____ - ____ Work # (____) ____ - ____ Cell # (____) ____ - ____

Birth Date: ____ / ____ / ____ ___ Single ___ Married ___ Divorced ___ Widowed ___ Domestic Partner

Employer _____

Preferred Pharmacy: _____ Location: _____

To communicate with us electronically please provide your email address:

POLICYHOLDER INFORMATION

(if different than above)

Full Legal Name: Last _____ First _____ M _____

Address: Street/Box _____ Apt # _____

City _____ State _____ Zip _____

Home # (____) ____ - ____ Work # (____) ____ - ____ Cell # (____) ____ - ____

Birth Date: ____ / ____ / ____ Relationship to Patient: _____

Employer _____

By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we cannot alter your claim, change your diagnosis, or report a different service than what was performed so that your insurance will cover the charges.

EMERGENCY NOTIFICATION

Name _____ Relationship to Patient _____

Home # (____) ____ - ____ Work # (____) ____ - ____ Cell # (____) ____ - ____