Harbour Healthcare, Inc.

719 High Street, Suite 118
Portsmouth, VA 23704
(PHONE) 866.601.4443 (FACSIMILE) 866.596.6056
www.myharbourhealthcare.com

Name: **Preferred/Nickname:** **Date:** / /

Registration

I am a ☐ guardian ☐ power of attorney ☐ N/A (not applicable)

- **Address/City-State-Zip:** _____
  Phone: ( ) - _____-_____ **Cell Phone:** ( ) - _____-_____
  Preferred email: _____ @ _____._____
  SS# or Legal ID: _____ **Birthday:** ___/___/_____ **Age:** ____
- **Marital Status (circle)**:
  ☐ Single ☐ **P**artner ☐ **M**arried ☐ **SO** ☐ **S**eparated ☐ **D**ivorced ☐ **W**idow(er)
- **My preferred contacts are:**
  ☐ **H**ome ☐ **W**ork ☐ **C**ell/**M**obile ☐ **e**Mail ☐ **S**pouse ☐ **M**ail ☐ **All**
- **Work information**
  Occupation/Position: _____ ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Unemployed
  Employer: _____
  Work Address/City State Zip: _____
  Work Phone: _____

- **Family:** ☐ N/A
  Spouse name: _____ **Contact Information is**: ☐ Same ☐ Different
  (If different) Address/City State Zip: _____
  Occupation/Position: _____ ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Unemployed
  Children names:
  Name: _____ ☐ M ☐ F ☐ X Age: ____ **Name**: _____ ☐ M ☐ F ☐ X Age: ____
  Name: _____ ☐ M ☐ F ☐ X Age: ____ **Name**: _____ ☐ M ☐ F ☐ X Age: ____

  If spouse is the primary insured, please complete **Spouse DOB**: _____/____/_____
  Spouse Employer: _____
  Work Address/City State Zip: _____
  Work Phone: _____
- **Emergency Contact**:
  Name: ☐ Mr. _____ ☐ Mrs. _____ ☐ Ms. _____ ☐ Dr. _____
  Phone: (_____)_____-_____ **Relationship**: _____

Financial responsibility **BRING YOUR ID AND INSURANCE WITH YOU TO THE VISIT**

☐Self-Cash/Check/CC ☐Employer ☐Lien ☐Power of Attorney ☐Insurance
(all payments are due at the time of service unless other arrangements have been made in advance)

I, _____, certify that the information provided on this form and providing to on any subsequent information with Harbour Healthcare, is true to the best of my knowledge.

(sign) _____ ***(date)*** ____/_____/_____