

REGISTRATION FORM

(Please Print)

Today's Date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Mr. Mrs.	Miss Ms.	Marital status: Single Mar Div Sep Wid
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Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: M F
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Street address: _____ Social Security no.: _____ Home Phone: _____ Cell No: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: _____

Chose clinic because/referred to clinic by (Please check one box):
 Family Friend Close to home/work Yellow Pages Other Insurance plan Hospital

Other family members seen here: _____ EMAIL: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Home phone no.: _____

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____

Is this patient covered by insurance? Yes No

Please indicate primary insurance Subscriber's Name: _____ Group No: _____ Policy No: _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: _____ Group no.: _____ Policy no.: _____ Co-payment: _____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian Signature	Date:	
REV: 7 / 2010		