REGISTRATION FORM

Today's Date: [Date]			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: [Last Name] First: [First Name]		Middle: [Initial] [Choose an item]		Marital status: [Choose an item]	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: [Birthday]	Age: [Age]	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.: [SS#]		Home phone no.: [Phone]		Cell phone no.: [Phone]	
Occupation: [Occupation]		Employer: [Employer]		Employer phone no.: [Phone]	
Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item]					
Other family members seen here: [Other patients]					
INSURANCE INFORMATION (Please give your insurance card to the receptionist.)					
Person responsible for bill: [Responsible party]	Birth date: [Birthday]	Address (if different): [Address]		Home phone no.: [Phone]	
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance? ○ Yes ○ No			
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]		Employer phone no.: [Phone]	
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name: [Name]	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.: [Group #]	Policy no.: [Policy #]	Co-payment: $[Co-pay]
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable): [Secondary Insurance]		Subscriber's name: [Name]		Group no.: [Group #]	Policy no.: [Policy #]

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
[Friend or relative name]	[Relationship]	[Phone]	[Phone]

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