REGISTRATION FORM

Please present: Insurance Card(s) and Photo Identification

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	○ Mr. ○ Mrs.	○ Miss ○ Ms.	Marital status (circle one) ○ Single / ○ Mar / ○ Div / ○ Sep / ○ Wid	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	E-Mail Address	Birth date:	Age:	Sex: ○ M ○ F	
Street address:		Social Security no.:		Home phone no.:		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:		Employer phone no.:			
Chose clinic because/Referred to clinic by (please check one box):		○ Dr.	○ Insurance Plan	○ Hospital		
○ Family	○ Friend	○ Close to home/work	○ Yellow Pages	○ Other		
Other family members seen here:						

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:	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*

Submit