

PATIENT REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| Today’s Date:  | PCP:  |

**PATIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s last name:  | First:  | Middle:  |  | Marital status:  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: |
|  |  |  |  |  |

Address:

|  |  |  |
| --- | --- | --- |
| Social Security no.: | Home phone no.: | Cell phone no.: |
|  |  |  |
| Occupation: | Employer: | Employer phone no.: |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Chose clinic because/referred to clinic by (Please choose one option): |  |  |
|  |  |  |

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? |  | Is this patient covered by insurance? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|  |  |  |  |

Please indicate primary insurance: | Other:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
|  |  |  |  | $ |

Patient’s relationship to subscriber: | Other:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
|  |  |  |  |

Patient’s relationship to subscriber: | 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 or insurance company to release any information required to process my claims.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | Patient/Guardian signature |  | Date |  |

 |