

PATIENT REGISTRATION FORM

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