



## REGISTRATION FORM

(Please Print)

Today's date:				PCP:				
PATIENT INFORMATION								
Patient's last name:		First:		Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:	Employer:	Employer address:				Employer phone no.:		( )
Pharmacy Name / Location :				Pharmacy Phone #:				
Please indicate primary insurance		Policy Name:						<input type="checkbox"/> Other
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	<b>Co-payment:</b> \$		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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*