



REGISTRATION FORM

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: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
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: () Mobile phone: ()	
P.O. box:		City:		State:		ZIP Code:
Occupation:		Employer:		Employer phone no.: ()		
Referred 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"/> Other	Please specify:			
Email Address:					<input type="checkbox"/> I would like to receive practice newsletters.	

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.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
INSURANCE:					Co-payment: \$
Subscriber's name:		Birth date:	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
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/Cell 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.					
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>	