## [Name of Practice]

# REGISTRATION FORM

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

PATIENT INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s last name: [Last Name] | First: [First Name] | Middle: [Initial] | [Choose an item] | Marital status: [Choose an item] |

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| --- | --- | --- | --- | --- | --- |
| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: |
|  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |

Address: [Address/ P.O Box, City, ST ZIP Code]

|  |  |  |
| --- | --- | --- |
| Social Security no.: | Home phone no.: | Cell phone no.: |
| [SS#] | [Phone] | [Phone] |
| Occupation: | Employer: | Employer phone no.: |
| [Occupation] | [Employer] | [Phone] |

|  |  |  |
| --- | --- | --- |
| Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] |
|  |  | [Choose an item] |

Other family members seen here: [Other patients]INSURANCE INFORMATION(Please give your insurance card to the receptionist.)

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| --- | --- | --- | --- |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
| [Responsible party] | [Birthday] | [Address] | [Phone] |
| Is this person a patient here? |  | Is this patient covered by insurance? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
| [Occupation] | [Employer] | [Address] | [Phone] |

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
| [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |

Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

|  |  |  |  |
| --- | --- | --- | --- |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
| [Secondary Insurance] | [Name] | [Group #] | [Policy #] |

Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]IN CASE OF EMERGENCY

|  |  |  |  |
| --- | --- | --- | --- |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
| [Friend or relative name] | [Relationship] | [Phone] | [Phone] |

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.

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

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