



## PATIENT REGISTRATION FORM

(Please Print)

Today's date:					PCP:						
<b>PATIENT INFORMATION</b>											
Patient's last name:			First:		Middle:		<input type="checkbox"/> Jr. <input type="checkbox"/> Sr.	<input type="checkbox"/> III <input type="checkbox"/> Dr.	If Minor legal guardians 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 / cell Phone #			
								H( )			
								C( )			
City:				State:				ZIP Code:			
Occupation:			Employer:				Employer phone no.:				
							( )				
How did you hear about our practice, referred by: <i>please check one</i>							<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Internet		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other					
Other family members seen here:											
<b>INSURANCE INFORMATION</b>											
<i>(Please give your insurance card to the receptionist.)</i>											
Person responsible for bill:		Birth date:		Address (if different):				Home phone / cell Phone #			
		/ /						H( )			
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No					C( )			
Occupation:	Employer:	Employer address:				Employer phone no.:					
						( )					
Is this patient covered by insurance?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insurance Company Phone #: ( )						
Please indicate primary insurance			<input type="checkbox"/> Blue Cross		<input type="checkbox"/> Aetna		<input type="checkbox"/> United		<input type="checkbox"/> Humana		<input type="checkbox"/> Coventry
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Assurant		<input type="checkbox"/> company self insurance			<input type="checkbox"/> Other				
Subscriber's name:		Subscriber's S.S. no.:		Birth date:		Group no.:		Policy no.:		Co-payment:	
				/ /						\$	
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					
<b>IN CASE OF EMERGENCY</b>											
Name of local friend or relative ( <i>not living at same address</i> ):				Relationship to patient:		Home phone no.:		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.											
Patient/Guardian signature							Date				