  
**REGISTRATION FORM**

(Please Print)

Today’s Date / / PCP

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last Name First Middle | | | | | | | | | | | Mr. Miss  Mrs. Ms. | | | | | | Marital Status (Circle One)  Single / Mar/ Div / Sep / Wid | | | | | |
| Is this your legal name?  Yes No | | If not, what is your legal name? | | | | | (Former Name) | | | | | Birth Date  / / | | | | | | Age | | | | Sex  M F |
| Street Address City State Zip Code | | | | | | | | | Social Security | | | | | | Home Phone No.  ( )  Alternate No.  ( ) | | | | | | | |
| Email Address: | | | | | | | | |
| P.O. Box City State Zip Code | | | | | | | | | | | | | | | | | | | | | | | |  |
| Occupation/Student | | | Employer/School | | | | | | | | Employer Phone No.  ( ) | | | | | | | | | | | | |
| Choose Clinic Because/Referred to Clinic by (Please check one box) Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance plan Hospital  Family Friend Close to Home/Work Yellow Pages Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| Other Family Members Seen Here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)** | | | | | | | | | | | | | | | | | | | | | | |
| Person Responsible for Bill | | | | Birth Date  / / | | Address (if different) | | | | | | | | | | Home Phone No. ( ) | | | | | | |
| Is this person a patient  here? Yes No | | | | | |  | | | | | | |
| Occupation | Employer | | | | Employer Address | | | | | | | | | | | Employer Phone No. | | | | | | |
| Is this patient covered by insurance? Yes No | | | | | | Please indicate your insurance Name and Phone Number | | | | | | | | | | | | | | | | |
| Subscriber Name | | Subscriber S.S.# | | | | Birth Date  / / | | | | Group # | | | Policy # | | | | | | | Co -payment  $ | | |
| Patient’s Relationship to Subscriber Self Spouse Child Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| Name of secondary Insurance (if applicable) Subscriber’s Name | | | | | | | | | | | | | Group # | | | | | | Policy # | | | |
| Patient’s Relationship to Subscriber Self Spouse Child 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.  ( ) | |