
**REGISTRATION FORM**

(Please Print)

Today’s Date / / PCP

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| --- |
| **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 patienthere? 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.( ) |