



REGISTRATION FORM

(Please Print)

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 (circle one) Single / Mar / Div / Sep / Wid				
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 #: Cell #:					
P.O. box:		City:		State:		ZIP Code:				
Occupation:		Employer:			Employer #: ()					
Chose clinic because/Referred to clinic 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"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other					
Other family members seen here:										
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										
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]			
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)		<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					
IN CASE OF EMERGENCY										
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()		Work 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					