

ALL AGES FAMILY MEDICINE

REGISTRATION FORM

(Please Print)

Today's Date:				PCP:			
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:	
						Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
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 phone no.:	
P.O. box:		City:			State:		ZIP Code:
Occupation:		Employer:			Employer phone no.:		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	
<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"/> 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			

