

PATIENT REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Sgl / Mar / Part / Sep / Div / 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
PO BOX	City	State	Zip Code	Preferred Phone Number ()		
Street Address		City	State	ZIP Code		
Employer	Occupation			Employer Phone No. ()		

HOW DID YOU HEAR ABOUT US?

Family Friend Close to Home/Work Yellow Pages Other _____

Other Family Members Seen Here:	What is the best way to contact you?
	Cell Phone: ()
	Email:

For Minors Only: Name of Mother _____ Name of Father: _____

BILLING INFORMATION

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, *Name of Person Responsible for bill _____			
Primary Insurance: (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)		*Address and Phone Number of Responsible Party (If different from above)			
Subscriber's Name	Employer	Occupation	Birth Date / /	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	Subscriber's Name		Employer	Birth Date / /	
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. ()
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The above information is true to the best of my knowledge.

X
PATIENT/GUARDIAN SIGNATURE

DATE