[Name of Practice]

# REGISTRATION FORM

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|---|---|---|---|---|---|
| Today's Date: [Date] | | | PCP: [PCP] | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: [Last Name] First: [First Name] | | Middle: [Initial] [Choose an item] | | Marital status: [Choose an item] | |
| Is this your legal name?<br>◯ Yes ◯ No | If not, what is your legal name?<br>[Legal Name] | Former name:<br>[Former Name] | Birth date:<br>[Birthday] | Age:<br>[Age] | Sex:<br>◯ M ◯ F |
| **IN CASE OF EMERGENCY** | | | | | |
| Name of local friend or relative (not living at same address):<br>[Friend or relative name] | | Relationship to patient:<br>[Relationship] | Home phone no.:<br>[Phone] | Work phone no.:<br>[Phone] | |

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