## [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? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: | |  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |   Address: [Address/ P.O Box, City, ST ZIP Code]   |  |  |  | | --- | --- | --- | | Social Security no.: | Home phone no.: | Cell phone no.: | | [SS#] | [Phone] | [Phone] | | Occupation: | Employer: | Employer phone no.: | | [Occupation] | [Employer] | [Phone] |  |  |  |  | | --- | --- | --- | | Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] | |  |  | [Choose an item] |   Other family members seen here: [Other patients] INSURANCE INFORMATION(Please give your insurance card to the receptionist.)  |  |  |  |  | | --- | --- | --- | --- | | Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | | [Responsible party] | [Birthday] | [Address] | [Phone] | | Is this person a patient here? |  | Is this patient covered by insurance? |  | | Occupation: | Employer: | Employer address: | Employer phone no.: | | [Occupation] | [Employer] | [Address] | [Phone] |   Please indicate primary insurance: [Choose an item] | Other: [Other insurance]   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: | | [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | | [Secondary Insurance] | [Name] | [Group #] | [Policy #] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber] IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | | [Friend or relative name] | [Relationship] | [Phone] | [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 |  | |

## [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? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: | |  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |   Address: [Address/ P.O Box, City, ST ZIP Code]   |  |  |  | | --- | --- | --- | | Social Security no.: | Home phone no.: | Cell phone no.: | | [SS#] | [Phone] | [Phone] | | Occupation: | Employer: | Employer phone no.: | | [Occupation] | [Employer] | [Phone] |  |  |  |  | | --- | --- | --- | | Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] | |  |  | [Choose an item] |   Other family members seen here: [Other patients] INSURANCE INFORMATION(Please give your insurance card to the receptionist.)  |  |  |  |  | | --- | --- | --- | --- | | Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | | [Responsible party] | [Birthday] | [Address] | [Phone] | | Is this person a patient here? |  | Is this patient covered by insurance? |  | | Occupation: | Employer: | Employer address: | Employer phone no.: | | [Occupation] | [Employer] | [Address] | [Phone] |   Please indicate primary insurance: [Choose an item] | Other: [Other insurance]   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: | | [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | | [Secondary Insurance] | [Name] | [Group #] | [Policy #] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber] IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | | [Friend or relative name] | [Relationship] | [Phone] | [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 |  | |

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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? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: | |  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |   Address: [Address/ P.O Box, City, ST ZIP Code]   |  |  |  | | --- | --- | --- | | Social Security no.: | Home phone no.: | Cell phone no.: | | [SS#] | [Phone] | [Phone] | | Occupation: | Employer: | Employer phone no.: | | [Occupation] | [Employer] | [Phone] |  |  |  |  | | --- | --- | --- | | Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] | |  |  | [Choose an item] |   Other family members seen here: [Other patients] INSURANCE INFORMATION(Please give your insurance card to the receptionist.)  |  |  |  |  | | --- | --- | --- | --- | | Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | | [Responsible party] | [Birthday] | [Address] | [Phone] | | Is this person a patient here? |  | Is this patient covered by insurance? |  | | Occupation: | Employer: | Employer address: | Employer phone no.: | | [Occupation] | [Employer] | [Address] | [Phone] |   Please indicate primary insurance: [Choose an item] | Other: [Other insurance]   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: | | [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | | [Secondary Insurance] | [Name] | [Group #] | [Policy #] |   Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber] IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | | [Friend or relative name] | [Relationship] | [Phone] | [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 |  | |