## [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] |  |  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 |  | |