

REGISTRATION FORM

Last Doctor seen:

Today's date:

PATIENT INFORMATION

Last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Preferred Contact method:			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address / PO Box:				Social Security #			Home phone # ()		
City:				State:		ZIP Code:		Cell Phone # ()	
Email:			Occupation / Employer:				Employer phone # ()		
Referred to clinic by (please check one box):					<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<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:									
Race:			Ethnicity			Preferred Language:			

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill:		Birth date: / /		Address (if different):			Home phone : ()		
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:				Employer phone: ()	
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Blue Cross - PPO		<input type="checkbox"/> Blue Cross HMO		<input type="checkbox"/> Blue Cross POS		<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	
<input type="checkbox"/> United Healthcare <input type="checkbox"/> Tricare		<input type="checkbox"/> Coventry		<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.:	
								\$	
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 : ()		Work phone: ()	
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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 Internal Medicine Associates of Jasper, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date