[Name of Practice]

REGISTRATION FORM

Today's Date: 05/31/2232			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: rand	First: sabie	Middle: v	[Choose an item]	Marital status: [Choose an item]	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: 05/3/1988 [Birthday]	Age: [Age]	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.: 888-88-8888 [SS#]	Home phone no.: 828-2323-1314 [Phone]		Cell phone no.: 213-242-5255 [Phone]		
Occupation: [Occupation]	Employer: Ban Ban [Employer]		Employer phone no.: 785-2525-5554 [Phone]		
Chose clinic because/referred to clinic by (Please choose one option): [Choose an item]	○ [Doctor's name] Dr. Ham Sausage ○				
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill: [Responsible party]	Birth date: [Birthday]	Address (if different): [Address]	Home phone no.: [Phone]		
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No		
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]	Employer phone no.: [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