

REGISTRATION FORM

(Please Print)

Today's date:		PCP:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (choose 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?	(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Social Security no.:		Home phone no.:			
City:	State:	Zip:	Cell phone no.:				
Occupation:	Employer:		Employer phone no.:				
Preferred Pharmacy:			Phone number:				
Other family members seen here:							
Email address:							

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:	Employer phone no.:			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> BCBS	<input type="checkbox"/> United	<input type="checkbox"/> Aetna	<input type="checkbox"/> Humana	<input type="checkbox"/> CIGNA
<input type="checkbox"/> TX True Choice	<input type="checkbox"/> PacifiCare	<input type="checkbox"/> Medicare	<input type="checkbox"/> Assurant	<input type="checkbox"/> Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	ID no.:	Co-payment: \$	
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.:	ID 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 no.:	Work phone no.:
		()	()
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.			