REGISTRATION FORM

Today's Date ____/____/____ (Please Print) PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (Circle One) ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to Home/Work ☐ Website ☐ Yellow Pages ☐ Other

Other Family Members Seen Here

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

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Tel: ( ) Email Address: Consent for Email Communications: ☐ Yes ☐ No
Is this person a patient here? ☐ Yes ☐ No			

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No
Please indicate primary insurance ☐ Aetna ☐ BCBS ☐ CIGNA ☐ Humana ☐ PHCS
☐ SPHN ☐ United ☐ Medicare ☐ Medicaid (Please provide coupon) ☐ Other

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ 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 the physicians and staff to provide me with reasonable and proper medical care. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize the insurance company and the clinic to release any information required to process my claims. I understand that the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice I agree to forward to the clinic all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

X _____ _____
PATIENT/GUARDIAN SIGNATURE DATE

PATIENT MEDICATION LIST

FOR YOUR SAFETY ALWAYS BRING YOUR MEDICATION LIST TO ANY HEALTHCARE PROVIDER				
Medication	Dose	Times to take in 24 hours	Purpose	Special Instructions

FOR YOUR SAFETY ALWAYS BRING YOUR MEDICATION LIST TO ANY HEALTHCARE PROVIDER				
Medication	Dose	Times to take in 24 hours	Purpose	Special Instructions