

ALL ABOUT FAMILY MEDICINE 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 (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? | | (Former name): | | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Social Security no.: | | 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): | | | | <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: | | | | | | | |

| 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: | | | | Group number: | | | |
| Member ID: | | | | | | | |
| Subscriber's name: | | Subscriber's S.S. no.: | Birth date: / / | Group no.: | | Policy 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.: | 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 no.: () |
| | | | Work phone no.: () |
| <p>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. Copay or deductible is due at time of service. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p> | | | |
| <hr style="width: 100%;"/> <i>Patient/Guardian signature</i> | | | <hr style="width: 100%;"/> <i>Date</i> |