NEW PATIENT REGISTRATION FORM

Today's Date: [Date]	PCP: [PCP]

PATIENT INFORMATION

Patient's last name: [Last Name] First: [First Name]	Middle: [Initial]	[Choose an item]	Marital status: [Choose an item]

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No	[Legal Name]	[Former Name]	[Birthday]	[Age]	○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
[SS#]	[Phone]	[Phone]
Occupation:	Employer:	Employer phone no.:
[Occupation]	[Employer]	[Phone]

Chose clinic because/referred to clinic by (Please choose one option):

○ [Doctor's name]

○ [Choose an item]

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
[Responsible party]	[Birthday]	[Address]	[Phone]
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:
[Occupation]	[Employer]	[Address]	[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): [Friend or relative name]	Relationship to patient: [Relationship]	Home phone no.: [Phone]	Work phone no.: [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