[Name of Practice]

REGISTRATION FORM

Today's Date: [Date]	PCP:

PATIENT INFORMATION

Patient's last name: First:	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.:	Primary phone no.:	Alternate phone no.:
[SS#]	Can we contact you here? ☐Yes ☐No Can we leave a detailed message? ☐Yes ☐No	Can we contact you here? ☐Yes ☐No Can we leave a detailed message? ☐Yes ☐No

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)

Primary insurance name:

Policyholder's name:	Subscriber's S.S. no.:	Date of Birth:	Group no.:	Policy no.:	Co-payment:
		[Birthday]			$

Patient's relationship to policyholder:

Will you receive sensitive services today or in the future? ☐Yes ☐No Do you have a Confidential Communications Request (CCR) in place? ☐Yes ☐No (if no, please go to the next question)	If you are not the policyholder, your insurance company has the authority to share some of your health information with the policyholder without your knowledge. Would you like to request that your insurance company not share your health information with your health plan's owner by submitting a Confidential Communications Request (CCR)? ☐Yes ☐No

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.

Patient/Guardian signature _____ Date _____