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PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's Date: _____ Who Referred You: _____

CLIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Mr. Mrs. Miss Ms

Is this your legal name? Yes No If not, what is your legal name? _____ Former Name: _____

Birth date: _____ Age: _____ Single Married Divorced Separated Widow

Address: _____ PO Box: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Security No.: _____

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 Yellow Pages Other _____

Other family members seen here: _____

I will be paying today by: Cash Cheque Credit Card Debit Card

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: _____

Address (if different): _____ Phone (H): _____

Is this person a patient here? Yes No Occupation: _____ Employer: _____

Employer address: _____ Phone (B): _____

Is this patient covered by insurance? Yes No

Please indicate primary insurance: Insurance Welfare (Please provide coupon) Other

_____

Subscriber's name: _____ Subscriber's S.S. no.: _____

Birth date: _____ Group no.: _____ Policy no.: _____ Co-payment: $_____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____

Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

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IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____

Relationship to patient:_____Phone: (H)_____(B)_____

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.

_____	_____	_____
PRINTED NAME	PARENT/LEGAL GUARDIAN SIGNATURE	DATE