

## Community Family Medicine REGISTRATION FORM

(Please Print)													
Today's Date:						PCP:							
<b>PATIENT INFORMATION</b>													
Patient's last name:			First:		Middle:		Mr.	Miss	Marital status:				
							Mrs.	Ms.	Single	Mar	Div	Sep	Wid
Is this your legal name?		If not, what is your legal name?			(Former name):			Birth date:		Age:		Sex:	
Yes		No									M		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):				Dr.					Insurance plan		Hospital		
Family		Friend		Close to home/work		Yellow Pages		Other					
Other family members seen here:													
<b>INSURANCE INFORMATION</b>													
(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?		Yes		No									
Occupation:		Employer:		Employer address:			Employer phone no.:						
							( )						
Is this patient covered by insurance?			Yes		No								
Please indicate primary insurance													
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				
<b>IN CASE OF EMERGENCY</b>													
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. I also authorize or insurance company to release any information required to process my claims.</p>													
Patient/Guardian signature						Date							