REGISTRATION FORM

(Please Print)

Today's Date:	PCP:	PCP Ph #: ( )

PATIENT INFORMATION

Patient Last Name :	First Name:	Middle Name:

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:
			( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.		☐ Insurance plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

E-mail:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth Date:	Address (if different):	Home phone no.:
			( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	☐ Yes	☐ No			
Please indicate **Primary** insurance:	☐ MEDICAID	☐ STAYWELL	☐ HEALTHEASE	☐ AMERIGROUP	☐ BLUE CROSS
☐ AETNA	☐ TRICARE	☐ HUMANA	☐ UNITED HEALTH	☐ 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

PLEASE NOTE: IF YOU PROVIDE FALSE INFORMATION REGARDING YOUR **PRIMARY** INSURANCE COMPANY YOU MAY BE FINANCIALLY RESPONSIBLE FOR THE VISIT. Initial _____

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 P.E.N.S or the insurance company to release any information required to process my claims. Insurance is a contract between you and your insurance company; we will file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, not covered charges, secondary insurances, "usual and/or customary charges", etc. You are responsible for the timely payment of the patient's accounts. I agree that any balance not covered by your insurance will be paid by the responsible party.

Patient/ Guardian Print Name:

Patient/Guardian Signature:	*Date*