PATIENT REGISTRATION FORM

Please complete ALL fields in print. ***How did you hear about us**? _____

PATIENT INFORMATION				
Name: LAST FIRST M.I.				**Gender** Male ❑ Female ❑
Date of Birth / /	**Primary Care Physician (PCP):**			
Address:	**City**:		**State**:	**Zip Code**:
Home Phone ( ) -	**Alternate Phone** ( ) -			
PRIMARY INSURANCE & SUBSCRIBER INFORMATION				
Primary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /			
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
SECONDARY INSURANCE				
Secondary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /			
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
TERTIARY INSURANCE				
Tertiary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /			
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
*If patient is a child, who may authorize treatment for this child?	*Relationship to Patient:	Phone No.: ( ) -		
Do you have a telephone answering machine or voicemail in your home? Yes ❑ No ❑ If so, may we leave messages from this office on that machine? Yes ❑ No ❑				
Do you authorize release of your medical information to anyone besides your insurance carrier(s)? Yes ❑ No ❑ If so, whom?				

_____ _____

Patient, Parent or Guardian's Signature **Date**