**Registration Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Preferred Provider:** | | | | | **Today’s Date:** | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | | | | | | |
| **Patient Name:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(Last) (First) (M.I.)** | | | | | | **Mr.**  **C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngMiss.**  **C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngMrs.** | | | **Marital Status**  **Single/ Mar/ Div / Sep / Wid** | | | | |
| **Social Security No:** | | | | **Primary Phone No:** | | | | | | | | | |
| **Is this your legal name?**  **C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Yes C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png No** | **Email Address:** | | | | | | **Birth Date**  **/ /** | | | | **Age** | | **Sex**  **C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngM C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngF** |
| **Street Address:** | | | **City:** | | | | | | | **State** | | **Zip Code** | |
| **Occupation:** | | **Employer:** | | | | | | **Employer Phone No:** | | | | | |
| **How did you hear about us? C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngInsurance C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Hospital**  **C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Family C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Friend C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| **Other family members seen at Family Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INSURANCE INFORMATION**  **(Please bring insurance card to appointment)** | | | | | | | | |
| **Does above patient have insurance: C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png No C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Yes** | | | | | | | | |
| **Person Responsible for bill:** | | **Birth date** | | | **Address (if different from patient):** | | | |
| **Is responsible party a patient here? C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png No C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].png Yes** | | | | **Phone Number:** | | | | |
| **Please Indicate Primary Insurance(i.e. BCBS, UHC, Medcost, Medicaid, Medicare):** | | | | | | | | |
| **Subscriber’s name:** | **Subscriber’s S.S. no:** | | | | | **Birth Date** | **Group No.** | **Policy No.** |
| **Patient’s Relationship to Subscriber: C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngSelf C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngSpouse C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngChild C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **Secondary Insurance (if applicable):** | | | **Subscriber’s Name** | | | | **Group No.** | **Policy No.** |
| **Patient’s Relationship to Subscriber: : C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngSelf C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngSpouse C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngChild C:\Users\tnewman\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\5V9I4FQP\Ic_check_box_outline_blank_48px.svg[1].pngOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **EMERGENCY CONTACT** | | | |
| **Name of Relative or Friend:** | **Relationship to Patient** | **Primary Phone No.** | **Secondary Phone No.** |
| **The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FamilyCare or my insurance company to release any information required to process my claims.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Patient/Guardian Signature Date*** | | | |