**Registration Form**

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **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*** |