

4 Your Health

REGISTRATION FORM

Today's Date: [Date]		PCP: [PCP]			
PATIENT INFORMATION					
Patient's last name:		First:	Middle: [Initial]	[Choose an item]	Marital status: [Choose an item]
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Former name:		Birth date: [Birthday]	Age: Sex: <input type="radio"/> M <input type="radio"/> F
Address:					
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
Chose practice because/referred to practice by (Please choose one option):					
		<input type="radio"/> [Doctor's name]			
		<input type="radio"/> [Choose an item]			
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: [Birthday]	Address (if different):		Home phone no.:	
Is this person a patient here?	<input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance?		<input type="radio"/> Yes <input type="radio"/> No	
Occupation:	Employer:	Employer address:		Employer phone no.:	
Please indicate primary insurance: [Choose an item] Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: [Birthday]	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: [Choose an item] Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: [Choose an item] Other: [Relationship to subscriber]					
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 4 Your Health or insurance company to release any information required to process my claims.					
_____ Patient/Guardian signature			_____ Date		