FAMILY HEALTHCARE, LLC

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REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Email Address:		Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:	Social Security no.:		Home phone no.: ( )			
Cell phone no.: ( )	City:	State:	ZIP Code:			
Occupation:	Employer:		Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Other						
Other family members seen here:						
Race:	Ethnicity:	Language:				

INSURANCE INFORMATION			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Primary Insurance Co:	Policy No.:		Group No.:
Subscriber's Name:	Date of Birth:	Relationship to Patient:	
Secondary Insurance Co:	Policy No.:		Group No.:
Subscriber's Name:	Date of Birth:	Relationship to Patient:	

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 Family Healthcare or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

May we share your medical information with this person? NO or if YES (Must also be listed on your contact permission form)