

REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Marital status:	
Is this your legal name?	If not, what is your legal name?	Former name:		Birth date:	Age: Sex:
<input type="radio"/> Yes <input type="radio"/> No					<input type="radio"/> M <input type="radio"/> F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
Chose clinic because/referred to clinic by (Please choose one option): <input type="radio"/>					
Other family members seen here: [Other patients] <input type="radio"/>					
INSURANCE INFORMATION					
Person responsible for bill:	Birth date:	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: _____ Other: _____					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	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: _____					
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 PREMIUM UNITED CARE LLC. or insurance company to release any information required to process my claims.					
Patient/Guardian signature				Date	