

# THE PERSONAL PHYSICIAN REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
City:		State:		Zip:	Cell phone no.: (    )		
Occupation:		Employer:			Employer phone no.: (    )		
Preferred Pharmacy:					Phone number: (    )		
Other family members seen here:							
Email address:							

<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: (    )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: (    )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> BCBS	<input type="checkbox"/> United	<input type="checkbox"/> Aetna	<input type="checkbox"/> Humana	<input type="checkbox"/> CIGNA	
<input type="checkbox"/> TX True Choice	<input type="checkbox"/> PacifiCare	<input type="checkbox"/> Medicare	<input type="checkbox"/> Welfare <i>(Please provide coupon)</i>		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		ID no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	ID no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: (    )	Work phone no.: (    )	
<p>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 [Name of Practice] or insurance company to release any information required to process my claims.</p>							
_____ <i>Patient/Guardian signature</i>					_____ <i>Date</i>		

