My Family Physicians

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City	State:	Zip Code:	Cell No.: ( )

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 ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(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? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary insurance Name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	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 My Family Physicians, Inc or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*