HEALTHY LIVING FAMILY MEDICAL CENTER

REGISTRATION FORM

Today's Date: [Date]			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: [Last Name] First: [First Name]		Middle: [Initial] [Choose an item]		Marital status: [Choose an item]	
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: [Birthday]	Age: [Age]	Sex: ◯ M ◯ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.: [SS#]	Home phone no.: [Phone]	Cell phone no.: [Phone]			
Occupation: [Occupation]	Employer: [Employer]	Employer phone no.: [Phone]			
Chose clinic because/referred to clinic by (Please choose one option): ◯ [Doctor's name] ◯ [Choose an item]					
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill: [Responsible party]	Birth date: [Birthday]	Address (if different): [Address]	Home phone no.: [Phone]		
Is this person a patient here? ◯ Yes ◯ No		Is this patient covered by insurance?	◯ Yes ◯ No		
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]	Employer phone no.: [Phone]		
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name: [Name]	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.: [Group #]	Policy no.: [Policy #]	Co-payment: $[Co-pay]
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable): [Secondary Insurance]		Subscriber's name: [Name]		Group no.: [Group #]	Policy no.: [Policy #]
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): [Friend or relative name]		Relationship to patient: [Relationship]	Home phone no.: [Phone]	Work phone no.: [Phone]	
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.					
Patient/Guardian signature			Date		