Hillcrest Family Medicine, P.A.

REGISTRATION FORM (Please Print)

Date:

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar/ Div/ Sep/ Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Date of Birth: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	Zip:

Home Phone Number:	Cell Phone Number:	SS#:

Occupation:	Employer:	Work Phone Number:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:	Email:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of Birth: / /	Address (if different than patient):	Home Phone Number:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:		Employer Phone Number:

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Company Name:

Subscriber's Name (If not patient):	Subscriber's S.S. Number:	Birth Date: / /	Group Number:	Policy Number:	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone number:	Work phone number:

The above information is true to the best of my knowledge. I authorize Hillcrest Family Medicine, P.A. to apply for benefits on my behalf for covered services rendered by Hillcrest Family Medicine, P.A. I request my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hillcrest Family Medicine or the insurance company to release any information required to process my claims.

Patient signature *Date*