REGISTRATION FORM

(Please Print)

Today's date: / /	Do you have an advanced directive? ❑ Yes ❑ No

PATIENT INFORMATION

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

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

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

P.O. box:	City:	State:	ZIP Code:

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	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

**** You must present your original card for us to bill your insurance carrier ****

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

Please indicate **primary** insurance	❑ Medicare	❑ Anthem BC/BS	❑ Cigna	❑ United Healthcare	❑ Aetna

❑ Tricare	❑	❑		❑ Other

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 (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 and may be relied upon. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Family Medicine at Lansdowne or insurance company to release any information required to process my claim(s). I further acknowledge receipt of the financial policy and HIPPA statement(s).

Patient/Guardian signature *Date*