

**[NAME OF PRACTICE]
REGISTRATION FORM**
(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
		Marital status: <input checked="" type="checkbox"/> Single / <input checked="" type="checkbox"/> Mar / <input type="checkbox"/> Div / <input type="checkbox"/> Sep / <input type="checkbox"/> Wid	
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:
<input type="checkbox"/> Yes <input type="checkbox"/> No			Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:	Home phone no.:
			()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.:
			()
Choose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital			
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> 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? <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"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance]					
<input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> Waiver (Please provide coupon) <input type="checkbox"/> Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy 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.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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. 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.			
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web 11 the discography of american rapper t i consists of eleven studio albums one compilation album one remix album four extended plays eps 13 mixtapes 110 singles including 61 as a featured artist and 11 promotional singles he has also released

one music video album and over 60 music videos the details of which are

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