

**[NAME OF PRACTICE]  
REGISTRATION FORM**

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Today's date:		POP:			
<b>PATIENT INFORMATION</b>					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<input type="checkbox"/> Single / <input type="checkbox"/> Mar. / <input type="checkbox"/> Div. / <input type="checkbox"/> Sep. / <input type="checkbox"/> Wid.
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name): Birth date: 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 homework <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other					
Other family members seen here:					

<b>INSURANCE INFORMATION</b>						
(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"/> Welfare (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						

<b>IN CASE OF EMERGENCY</b>					
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.					
<input type="checkbox"/>			<input type="checkbox"/>		
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**Calleen Coorough,James E. Shuman**

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*Information Management Report* ,2001

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Craig Van Slyke,France Bélanger,2002-09-27 Chapter 1 Introduction to Electronic Business Chapter 2

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Chapter 7 Client Server Technologies for E business Chapter 8 Integrating Back Office Communications Chapter 9 Providing Content for Electronic Business Chapter 10 Privacy and Security in E business Chapter 11 Electronic Payment Systems in E business Chapter 12 Electronic Business Architecture Glossary Index **Immigration & Nationality Law Handbook**

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