



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 (circle one) Single / Mar / Div / Sep / 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.: ()	
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		
<input type="checkbox"/> Social Media		<input type="checkbox"/> Other		<input type="checkbox"/> Dr. _____		
<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital				
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"/> 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.:

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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 Guided Life Care Planning Services or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date