Guided
Life Care Planning Services

# REGISTRATION FORM

(Please Print)

| | |
|---|---|
| Today's date: | PCP: |

## PATIENT INFORMATION

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient's last name: | First: | Middle: | ❑ Mr.<br>❑ Mrs. | ❑ Miss<br>❑ Ms. | Marital status (circle one)<br>Single / Mar / Div / Sep / Wid | | | | | | |
| Is this your legal name?<br>❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date:<br>/ / | Age: | Sex:<br>❑ M ❑ F | | | | | | |
| Street address: | Social Security no.: | Home phone no.:<br>( ) | | | | | | | | | |
| P.O. box: | City: | State: | ZIP Code: | | | | | | | | |
| Occupation: | Employer: | Employer phone no.:<br>( ) | | | | | | | | | |
| Guided Life Care Planning Services was referred by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital<br>❑ Family ❑ Friend ❑ Signage ❑ Social Media ❑ Other | | | | | | | | | | | |
| Other family members using our services: | | | | | | | | | | | |

## INSURANCE INFORMATION

(Please provide your insurance card.)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Person responsible for bill: | Birth date:<br>/ / | Address (if different): | Home phone no.:<br>( ) | | | | | | | | |
| Is this person a client completing the form? ❑ Yes ❑ No | | | | | | | | | | | |
| Occupation: | Employer: | Employer address: | Employer phone no.:<br>( ) | | | | | | | | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | | | | | | | | | |
| Please indicate primary insurance ❑ Florida Blue ❑ Beacon Health ❑ Aetna ❑ Cigna ❑ Medicaid ❑ Other | | | | | | | | | | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date:<br>/ / | Group no.: | Policy no.: | Co-payment:<br>$ | | | | | | |
| 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.:<br>(  ) | Work phone no.:<br>(  ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Guided Life Care Planning Services. 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.<br><br>*Patient/Guardian signature*  *Date* | | | |