Center for Internal Medicine
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REGISTRATION FORM

(Please Print)

Today's Date:	Preferred Pharmacy:	Pharmacy Phone #:

PATIENT INFORMATION

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

Street Address:	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

City	State:	Zip Code:	Home Phone #: ( )	Cell Phone #: ( )

Occupation:	Employer:	Employer Phone #: ( )

Chose clinic because / Referred to clinic by (please check one box):

❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth Date: / /	Address (if different)	Home Phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer Phone #: ( )

Is the patient covered by Insurance? ❑ Yes ❑ No

Please indicate primary insurance:	❑ Workers Compensation	❑ Medicare	❑ Medicaid	❑ BCBS	❑ Humana	❑ United Health Care	❑ Aetna	❑ Cigna	❑ Other _____

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

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 #:	Work phone #:

☐ *(Initials)*

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 ***Center for Internal Medicine*** or Insurance Company to release any information required to process my claims.

☐ *(Initials)*

Missed/No show appointments may incur fee.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative of the patient acknowledges that he or she was informed of the ***Center for Internal Medicine,*** Notice of Privacy Policies, as posted at the front desk, and available upon request, on the date below.

_____
Patient / Responsible Party for Signature

_____
Date