ROCHESTER FAMILY MEDICINE - PC

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Rochester Hills, MI 48309

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Rochester Family Medicine PC
PATIENT REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

How did you hear about us:	○ Referred by Dr. _____ ○ Other: _____

*Race/Ethnicity_____ (If you decline to declare, write "Decline")

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? ○ Yes ○ No		Is this patient covered by insurance? ○ Yes ○ No	
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: 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 Rochester Family Medicine PC or insurance company to release any information required to process my claims.

_____   _____
Patient/Guardian signature   Date

* U.S. government required statistical data necessary for all healthcare entities to attain "Meaningful Use" of Electronic Health Record

(Please return completed form to front desk)