2020 REGISTRATION FORM

Today's Date:	PCP:	PCP Ph #: ( )

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:

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

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Race:	☐ American Indian or Alaska Native ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Hispanic ☐ Asian ☐ Other Race (please specify) ______________________________
Ethnicity:	☐ Hispanic or Latino ☐ Non Hispanic or Latino
Preferred Language:	☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other (please specify) ______________________

Referred to clinic by (Please check one box):	☐ Dr. ______________	☐ Insurance plan	☐ Hospital

E-mail address:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

INSURANCE INFORMATION

Person responsible for bill:	Birth Date:	Address (if different):	Home phone no.:
			( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	☐ Yes	☐ No

Please indicate **primary** insurance:	☐ MEDICAID/MEDIPASS	☐ STAYWELL	☐ HEALTHEASE	☐ AMERIGROUP	☐ BLUE CROSS
☐ AETNA	☐ TRICARE	☐ HUMANA	☐ UNITED HEALTH	☐ Other	

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

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

PLEASE NOTE: IF YOU PROVIDE FALSE INFORMATION REGARDING YOUR **PRIMARY** INSURANCE COMPANY YOU MAY BE FINANCIALLY RESPONSIBLE FOR THE VISIT. Initial ________

Insurance is a contract between you and your insurance company; we will file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, not covered charges, secondary insurances, "usual and/or customary charges", etc. You are responsible for the timely payment of the patient's accounts. You agree that any balance not covered by your insurance will be paid by the responsible party.

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 PENS or the insurance company to release any information required to process my claims.

Patient/Legal Guardian Print Name:

Patient/Legal Guardian Signature:	*Date*