COMPLETE CARE PHYSICIANS

REGISTRATION FORM

PATIENT INFORMATION

Patient Last Name:	First Name:	Middle Name:

Email:	Date of Birth:	Single, Married, Widow, or Divorced	Age	Sex: ○ M ○ F

Address, City, & State, Zip Code:

Social Security:	Home phone:	Cell phone:
Occupation:	Employer:	Employer phone:

Referred by: Pharmacy: Name/Phone Number:

INSURANCE INFORMATION

(Please give your insurance and driver's license card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone:
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:

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

Patient's relationship to subscriber:

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone.:	Work phone:

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 COMPLETE CARE PHYSICIANS or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date