The Family Practice Center of Sulphur

REGISTRATION FORM

(Please Print)

Today's Date:	Physician:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	o Mr. o Mrs.	o Miss o Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

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

Street Address:	Social Security No.:	Home Phone No.: ( )

City:	State:	ZIP Code:	Cell Phone No.: ( )

Occupation:	Employer:	Employer Phone No.: ( )

Chose clinic because/Referred to clinic by (please check one box):	o Dr.	o Insurance Plan	o Hospital

o Family	o Friend	o Close to home/work	o Yellow Pages	o Other

Other family members seen here:

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? o Yes o No

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

Is this patient covered by insurance? o Yes o No

Please indicate primary insurance	o Medicare	o Blue Cross	o Aetna	o United Healthcare	o Cigna

o RR Medicare	o State Group	o Other

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	o Self	o Spouse	o Child	o Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's Relationship to Subscriber:	o Self	o Spouse	o Child	o Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

Please turn over to complete