PATIENT REGISTRATION FORM

**Today's Date: 02/02/2023 *Clinic Name:* MCPEDS & HEALTH CENTER

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

*Pharmacy Name: _____ Work Phone #: (_____) _____-_____

E-mail Address: _____ Cell Phone #: (_____) _____-_____

Emergency Contact Name: _____ Emerg Phone #: (_____) _____-_____

Please tell us how you heard about us: _____ *Referred by* _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self ____ Spouse ____ Parent ____ Other _____

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address: _____

_____ Work Phone #: (_____) _____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

Confidential Proprietary Information