### Ben Hankins, MD

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | First: | | | | | Middle: | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | | Marital status (circle one) | | | | | | | |
|  | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | |
| 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: | | | | | |
|  | | | | | |  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Occupation: | | | | | | Employer: | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | ❑ Insurance Plan | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | ❑ Close to home/work | | | | ❑ Yellow Pages | | | | | | | | | ❑ Other | | | | | |  | | | | | | | | | |
| Other family members seen here: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 Ben Hankins, MD or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | |  | | | Date | | | | | | | | | | |  |