Print Form

NORTH ISLAND MEDICAL
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

First: Middle: Last:

Social Security No.:

Marital status:
☐ Single ☐ Married
☐ Partnered ☐ Widowed
☐ Divorced ☐ Separated

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

Street address:	Cell Phone No.: ( )	Home Phone No.: ( )

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

Occupation:	Employer:	Employer Phone No.: ( )

Email address:	Preferred method of contact:

INSURANCE INFORMATION: PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone No.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Insurance Co:

Subscriber's name:	Subscriber's SSN:	Birth date:	Group No.:	Policy No.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other

Secondary Insurance:	Subscriber's Name:	Group #	Policy #

IN CASE OF EMERGENCY

Name of local friend or relative:	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 North Island Medical or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*