DOCTORS COMMUNITY HOSPITAL | DOCTORS COMMUNITY PRACTICES

Registration Form

PATIENT ID LABEL

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name:_____ First: _____ Middle:_____

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital Status (circle one) Single / Mar / Div / Sep / Wid Birth Date: _____ Age: _____ Sex: ❑ M ❑ F

Social Security Number: _____ Home Phone Number: _____ Cell Number: _____

Email Address:_____

Street Address: _____

P.O. Box: _____ City:_____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Work Phone Number:_____

Referring Provider Name: _____

Referring Provider Phone and Fax Numbers: _____

Primary Physician Name: _____

Primary Physician Phone and Fax Numbers: _____

Preferred Pharmacy Name and Address: _____

Preferred Pharmacy Phone and Fax Numbers: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person Responsible for the Bill: _____ Birth Date: _____

Address (if different): _____ Home Phone Number: _____

Name of Insurance: _____ Subscriber's Name: _____

Subscriber DOB: _____ Subscribers Social Secuity Number: _____

Policy Number: _____ Group Number: _____ Co Pay Amount: $ _____

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

Name of Secondary Insurance(if applicable): _____ Subscriber's Name: _____

Policy Number: _____ Group Number: _____

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

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at the same address):_____

Relationship to Patient: _____ Home Phone Number: _____ Work Phone Number: _____

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 Doctors Community Practices, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____