PATIENT REGISTRATION FORM

(Please Print)

Today's Date: ______________________________ Primary Care Physician: ______________________________

PATIENT INFORMATION

Last Name: ____________________________________ First Name: ______________________ Middle Initial: _____

Former/Maiden Name: __________________________________ Marital Status (circle one): Single Mar Div Sep Wid

Social Security Number: ______________________________ Birth Date: _________________ Sex: O Male O Female

Home Phone Number: ________________ Cell Phone Number: _______________ Other Number: _______________

Street Address: ____________________________________ City: _____________ State: ____ Zip Code: __________

Race (circle one): White Hispanic/Latino American Indian/Alaskan Native Asian Black/African American
Native Hawaiian/Other Pacific Islander Other

Language Preference: ___________________________ Hearing Impaired: O Yes O No Vision Impaired: O Yes O No

Do you need an interpreter? O Yes O No Type: ____

Email Address: ____ Occupation: ___________________________

Employer: _______________________________________ Employer Work Number: __________________________

INSURANCE/FINANCIAL INFORMATION

(Please give your insurance card(s) and identification card/driver's license to the receptionist)

Is patient covered by Insurance: O Yes O No Primary Insurance Company: ______________________________

Subscriber's Name: ______________________________ Subscriber's SS #: _________________________________

Subscriber's Birth Date: _________________ Group #: __________ Policy #: __________ Employer: ______________

Employer Street Address: _____________________________ City: _____________ State: ____ Zip Code: __________

Employer's Phone Number: _________________________ Patient's Relationship to Insured: O Self O Spouse O Child

Is patient covered by a Secondary Insurance: O Yes O No Secondary Insurance Company: ______________________

Subscriber's Name: ______________________________ Subscriber's SS #: _________________________________

Subscriber's Birth Date: _________________ Group #: __________ Policy #: __________ Employer: ______________

Employer Street Address: _____________________________ City: _____________ State: ____ Zip Code: __________

Employer's Phone Number: _________________________ Patient's Relationship to Insured: O Self O Spouse O Child

Person Responsible for Bill: ____________________ Birth Date: __________ Primary Phone Number: ______________

Street Address: ____________________________________ City: _____________ State: ____ Zip Code: __________

IN CASE OF EMERGENCY

Name of Local Contact in an Emergency: ________________________________ Primary Number: ________________

This information is true to the best of my knowledge. I authorize my benefits be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize BARRY POINTE FAMILY CARE or insurance company to release any information required to process my claim.

Patient/Guardian Signature: ____ Date: _________________