Wattles Park Family Practice

Registration Form

Today's Date: Physician:

Patient Information

Patient's last name: First: Middle:			Mr. __ Mrs. __	Miss __ Ms. __	Marital Status (please circle) S / M / D / Sep. / W	
Street Address:	City:	State: Zip Code:		Date of Birth: / /	Age:	Sex: M F
Home phone number: ( )	Cell phone number: ( )		Work phone number: ( )			
Race: (please circle) African American/ American Indian /Alaskan Native /Asian / Hispanic / Mixed Race / White /Other / Refuse to Report Ethnicity: (please circle) Hispanic / Not Hispanic / Refuse to Report						
Employer:	Occupation:		Shift:	Email address:		
Social Security Number:	Spouses Name:		Date of Birth:			
Other family members seen here:						

Insurance Information

PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LICENSE/ID AT EVERY VISIT

Guarantor (Person responsible for bill):	Birth date: / /	Address (if different than patient):		Home phone number: ( )	
Is this person a patient here? (Please circle) Yes No					
Employer:	Occupation:	Employer Address:		Employer Phone: ( )	
Is the patient covered by insurance? (please circle) Yes No					
Please indicate primary Insurance:					
Subscriber Name:	Subscriber Social Security #	DOB / /	Group #	Policy #	Co-pay $
Relationship to subscriber: (please circle) self spouse child other (please list if other)					
Name of 2ndry Ins.	Subscribers Name:	Group #	Policy #		

IN CASE OF EMERGENCY

Name of local friend/relative (not living at same address)	Relationship to patient:	Home phone: ( )	Cell phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wattles Park Family Practice or my insurance company to release any information required to process my claims. I give my consent for Wattles Park Family Practice to provide treatment for my health care needs.

Patient/ Guardian Signature: Date: