MEDICAL ASSOCIATES

# PATIENT REGISTRATION FORM

Please print this form, fill out completely, and bring it with you to your first appointment.

For office use only:

Doctor Name _____ Appointment Date _____

Guarantor Number _____

History Number _____

## 1. PATIENT INFORMATION:

**Mr./Mrs./Ms. Name:** _____
Last First M.I.

**Previous or Maiden Name:** _____ **Sex:** M/F **Home Phone:** _____

**Address:** _____
Street City State Zip Code

**Birth Date:** ____ | ____ | ____ **Social Security Number:** _____
Month Day Year

**Employer:** _____ **Work Phone:** _____
Area Code

**Emergency Contact:** _____ **Relationship:** _____
Name

**Home Phone:** _____ **Work Phone:** _____

## 2. FAMILY MEMBER RESPONSIBLE FOR PAYMENT: **Same as above: Y/N** **SSN:** _____

**Mr./Mrs./Ms. Name:** _____
Last First M.I.

**Address:** _____
Street City State Zip Code

**Phone Number:** _____ **Relationship to Patient:** _____

## 3. PARENT OR SPOUSE INFORMATION (list both parents if patient is under the age of 18)

**Mother/Wife's Name:** _____ **Maiden Name:** _____

**Employer:** _____
Name City State Phone Number

**Father/Husband's Name:** _____

**Employer:** _____
Name City State Phone Number

## 4. INSURANCE INFORMATION

**Subscriber of the Insurance:** _____ **Birth Date:** _____

**Subscribers Address:** _____
Street City State Zip Code

**Relationship to patient:** _____ **Policy Number:** _____ **Effective Date:** _____

**Group Number:** _____ **Insurance Carrier Phone Number:** _____

**Family Members covered:** _____ **Co-pay Amount:** _____