PATIENT REGISTRATION

Patient Information	Guarantor/Insurance Subscriber Information
□ **No Insurance** □ **Patient Holds Insurance** □ **Other Person Holds Insurance**	**Information MUST be completed for insurance billing.**
Patient Full Name:	Guarantor Full Name:
Date of Birth: Gender: □ Male □ Female	Guarantor Date of Birth:
Primary Care Physician (PCP): PCP phone/fax.:	Primary Care Physician (PCP): PCP phone/fax.:
Marital Status: □ Child □ Single □ Married □ Divorced □ Widowed □ Separated	Guarantor Relationship to Patient:
Spouse's Full Name:	Guarantor Permanent Address: Apt No.:
Local Address: Apt No.:	City: State: Zip:
City: State: Zip:	Guarantor Primary Contact No.: □ Home □ Cell □ Work
Primary Contact No.: □ Home □ Cell □ Work	Guarantor Secondary Contact No.: □ Home □ Cell □ Work
Secondary Contact No.: □ Home □ Cell □ Work	Guarantor Employer:
Email Address:	Insurance Company:

Permanent Address:	Apt No.:
City: State:	Zip:
Employer:	
Primary Care Physician:	□ None □ Unknown
Who referred you to our clinic today?	

Minors and Incapacitated Adults Only

Guardian's Full Name:
Guardian's Contact No.:
Guardian's Relationship to Patient:

Type: □ HMO / PPO □ Medicare □ Medicaid/AHCCCS □ Tricare □ Other	
ID/Policy No.:	Group No.:
Copay Amount:	Effective Date:
Secondary Insurance? □ Yes □ No Name:	

Signature

Patient/Guardian Name:
Signature **Date**