

# HIGHGATE MEDICAL GROUP REGISTRATION FORM

(Please Print)

Today's Date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name? (Former name):		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members seen here:							

<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ( )	Work phone no.: ( )	
<p>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 [Name of Practice] or insurance company to release any information required to process my claims.</p>							
_____ <i>Patient/Guardian signature</i>					_____ <i>Date</i>		