REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security no.:	Nickname:	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Cell phone no.: ( )		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
E-mail:	Occupation and Employer:		Work phone no.: ( )			
Who may we thank for referring you to our office?						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Guarantor:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance:		***Does your insurance have a "Preferred Lab"? If so please list here:***			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

AUTHORIZATION

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Midwest Health Group or insurance company to release any information required to process my claims. I understand by providing by cell phone number automated messages in the form of appointment reminders may be sent to my cell phone number and I hereby give authorization. The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*