



REGISTRATION FORM

(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's Last Name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Social Security no.:	Nickname:	(Former name):	Birth date: / /
			Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> 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? <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:		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.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:		Co-payment: \$	
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:			

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	
<p>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.</p>	
_____ Patient/Guardian signature	_____ Date