



# PrimeCare Medical Center

"Our Emphasis is on Quality Healthcare"

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## REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Provider		
<b>PATIENT INFORMATION</b>					
Last name:		First:	Middle:	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.
Social Security no.:	Marital status (circle one) Single / Mar / Div / Sep / Wid		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			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	
<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					
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
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.: ( )	