COMMUNITY CARE PHYSICIANS, P.C.

PATIENT REGISTRATION FORM

General Information:

Patient's Name: ______________________ Date of Birth: ______________ Sex: ______

Address: ______________ City: ______________ State: ______ Zip: ______________

Home Phone #: ______________________ Cell Phone # ______________________

Social Security #: ______________________ Marital Status: S M D W (Circle One)

Responsible Party's Name: ______________________ Phone: ______________________

Address: ______________ City: ______________ State: ______ Zip: ______________

Pharmacy Name: ______________________ Phone: ______________________

Address: ______________ City: ______________ State: ______ Zip: ______________

Employer:

Name: ______________________

Address: ______________________

____

Work Phone: ______________________

❑ Workers Compensation ❑ No-Fault (Check One)

Date of Injury: ______________________

Policy Holders Employer:

Employer Name: ______________________

Address: ______________________

Work Phone: ______________________

Policy Holders Date of Birth: ______________________

❑ Workers Compensation ❑ No-Fault (Check One)

Date of Injury: ______________________

In Case Of Emergency Notify:

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Work Phone: ______________________

Are you interested in information about a Health Care Proxy ? ❑ yes ❑ no

Primary Insurance Information:

Plan Name: ______________________ I.D. Number: ______________________

Address: ______________________ Group Number: ______________________

Policy Holder: ______________________ Effective Date: ______________________

Policy Holders Social Security Number: ______________________

Secondary Insurance Information:

Plan Name: ______________________ I.D. Number: ______________________

Address: ______________________ Group Number: ______________________

Policy Holder: ______________________ Effective Date: ______________________

Policy Holders Social Security Number: ______________________

Tertiary Insurance Information:

Plan Name: ______________________ I.D. Number: ______________________

Address: ______________________ Group Number: ______________________

Policy Holder: ______________________ Effective Date: ______________________

Policy Holders Social Security Number: ______________________

I authorize the release of any medical information necessary to process this bill to my insurance company. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ______________________________ Date: ______________