# AFFILIATES IN INTERNAL MEDICINE
# REGISTRATION FORM

**BOLD PRINT IS REQUIRED**

| Today's Date: | PCP: |
|---|---|

**PATIENT INFORMATION**

| **Patient's last name:** **First:** | **Middle: [Initial]** | **Marital status: S [ ] M [ ] D [ ] W [ ]** |
|---|---|---|

| **Is this your legal name?** | **If not, what is your legal name?** | **Former name:** | **Birth date:** | **Age:** | **Sex:** |
|---|---|---|---|---|---|
| | | | | | |

**Address: [Address/ P.O Box, City, ST ZIP Code]**

| Social Security no.: | **Home phone no.:** | **Cell phone no.:** |
|---|---|---|
| Email: | Alt Phone no: | Alt Phone no: |
| Occupation: | Employer: | Employer phone no.: |

Race: _____Declined to Answer [ ] Ethnicity:_____ Declined to Answer [ ] Language:_____

Other family members seen here: _____

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

| **Person responsible for bill:** | **Birth date:** | **Address (if different):** | **Home phone no(if different):** |
|---|---|---|---|
| | | | |

**Patient's relationship to subscriber:** **Other:**

| **Name of primary insurance:** | **Subscriber's name:** | **Subscribers DOB:** **Effective Date:** | **Policy no.:** | **Group no.:** | **Co-payment:** **$** **Deductible:** |
|---|---|---|---|---|---|
| | | | | | |

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

| Name of secondary insurance (if applicable): | Subscriber's name: | Subscribers DOB: |
|---|---|---|
| Policy no.: | Group no.: | Effective Date: |

Patient's relationship to subscriber: Other:

**IN CASE OF EMERGENCY**

| Name of local friend /relative (not living at same address): | Relationship to patient: | Home phone no.: |
|---|---|---|
| Address | | Work phone no.: |

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.

Patient/Guardian signature Date: