

# SUPERIOR MEDICAL CLINIC REGISTRATION FORM

(Please Print)

Today's Date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>							
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date:	Age:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F							
Street address:				Social Security no.:		Home phone no.:	
(    )							
P.O. box:		City:			State:		ZIP Code:
Occupation:		Employer:			Employer phone no.:		
(    )							
If child Guardian name:							
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Other							

INSURANCE INFORMATION					
(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					
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 <input type="checkbox"/>					
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

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:
			(    )
			(    )
<p>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.</p>			
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>