TOTAL PRIMARY CARE

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Info:

Last_____First_____ Middle _____

Date of Birth: _____ Age: _____ Sex: M_____ F_____

Home address: _____

City:_____State:_____ Zip Code:_____

Home phone: _____Cell: _____ Email: _____

Occupation: _____ Marital Status: M_____ S_____W_____

Employer: _____Employer phone: _____

Patient Social Security # -_____

***** HOW DID YOU HEAR ABOUT US?_____***

Insurance Info: (***If insurance card is provided you do not need to fill out the following information.*****)**

Name of Subscriber: _____ DOB: _____Phone#: _____

Name of Insured:_____ Patient Relationship to Subscriber: _____

Address: _____City: _____ St: _____ zip: _____

Primary Ins Carrier: _____Policy #: _____Group #: _____

Secondary Ins: _____ Policy#: _____ Group#: _____

In case of Emergency:

Name of local friend or relative **NOT** living with you: _____

Relationship to Patient: _____ Home#: _____Cell#: _____

The above information is true to the best of my knowledge. I authorize my Insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Total Primary Care or Insurance Company to release any information required to process my claim.

Signature: _____ Date: _____