REGISTRATION FORM

(Please print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑Mr. ❑Mrs.	❑Miss ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑Yes ❑No	If not so, what is your legal name?	(Former name):	Date of birth:	Age:

Street address:	Social security no.:	Home phone #: Cell phone #:

P.O. BOX:	City:	State:	Zip code:

Occupation:	Employer:	Employer's phone no.:

Chose clinic because / Referred to clinic by (Please check one box):	❑Dr.	❑Insurance plan	❑hospital

❑Family	❑Friend	❑Close to home/Work	❑Other	Other relatives seen here:

Pharmacy:	Pharmacy phone number/address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of birth:	Address (if different):	Home phone no.:

Is this person a patient here? ❑Yes ❑No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ❑Yes ❑No

Name of primary insurance	Address:

Name of the primary insured:	Primary insured S.S. no.:	Date of birth:	Policy no.:	Group no.:	Copayment: $

Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other

Name of secondary insurance (if applicable):	Primary insured name:	Policy no.:	Group no.:

Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other

IN CASE OF EMERGENCY

Name of local friend or relative (Not living at the same address):	Relationship to patient:	Home phone no.:	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 Catherine Holt MD or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*