



REGISTRATION FORM

Last Doctor seen: _____

Today's date: _____

PATIENT INFORMATION

Name (Last, First, M.I.):		☐ M ☐ F	☐ Mr ☐ Mrs. ☐ Miss ☐ Ms.
Is this your legal name? ☐ Yes ☐ No		DOB: _____ Age: _____	
If not, legal name (Last, First, M.I.):		Preferred Contact Method: ☐ Home Phone ☐ Cell ☐ Email	
Street address / PO Box:		Home phone #:	
City / State / ZIP Code:		Cell phone #:	
Race (optional):	Ethnicity (optional):	Preferred Language:	Email:
Employer:	Occupation:	Employer phone #:	
Referred to clinic by: ☐ Dr ☐ Insurance ☐ Hospital ☐ Family ☐ Friend			
Other family members seen here:			

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Name of Person responsible for bill:		DOB:	
Address (if different):		Home phone:	
Is this person a patient here? ☐ Yes ☐ No	Employer:	Occupation:	Employer phone:
Is patient covered by insurance? ☐ Yes ☐ No	Primary Insurance:	Group #:	Policy #:
Subscriber name:		Subscriber DOB:	
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		Member ID:	Copay:
Secondary Insurance:		Group #:	Policy #:
Subscriber name:		Subscriber DOB:	

IN CASE OF EMERGENCY

Name of local friend or relative:			
Relationship:	Home phone:	Cell phone:	Work phone:

I certify the above information is true to the best of my knowledge. I authorize Prestige Medical Group to bill my insurance and release necessary information for payment, treatment, and healthcare operations. I understand I am financially responsible for any balance not covered by insurance.

Patient/Guardian name: _____

Patient/Guardian signature: _____

Date: _____