

REGISTRATION FORM

PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
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 Number:		Home phone number: ()		
City:				State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Who referred you to our office?		<input type="checkbox"/> Dr.		<input type="checkbox"/> Internet		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
e-mail:				Other phone / Cell phone: ()			

INSURANCE INFORMATION							
(Please give your insurance card and a picture ID 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							
Subscriber's name:		Subscriber's S.S. #:		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.:		Work phone no.:	
()		()	

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company (ies). The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Bechara Y. Ghorayeb, MD, PA.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I also authorize Bechara Y. Ghorayeb, MD, PA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and authorize the insurance company to release any information required to process my claims.

Patient/Guardian signature: _____

Date: _____