



REGISTRATION FORM

(Please print)

PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is it her legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not so, what is your legal name?		(Former name):		Date of birth: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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):				<input type="checkbox"/> Dr.		<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"/> Other		Other relatives seen here:	
Pharmacy:			Pharmacy phone number:				

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person in charge of Bill:		Date of birth: / /	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							
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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Primary insured name:			Policy no.:		Group no.:
Patient's relationship to primary insured:		<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 the same address):		Relationship to patient:	Home phone no.: ()	Work 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 Jordan L Mitchell MD or insurance company to release any information required to process my claims.</p>				
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Patient/Guardian signature</i>			<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Date</i>	

