
# REGISTRATION FORM

| Today's Date: | | | Primary Care Physician: | | |
|---|---|---|---|---|---|
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: First: | | Middle: | Marital status: | | |
| | | | If married, spouse's name: | | |
| Is this your legal name? ○ Yes ○ No | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: ○ M ○ F |
| Address: | | | | | |
| Email address: | | Home phone no: | Cell phone no: | | |
| Occupation: | | Employer: | Work no: | | |
| How did you find us? (Please choose one option): | | ○ Doctor: ○ Patient: ○ Internet (please choose one): Google Yelp ZocDoc Other: | | | |
| **INSURANCE INFORMATION** | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: | | |
| Is this person a patient here? | ○ Yes ○ No | Is this patient covered by insurance? | ○ Yes ○ No | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: | | |
| Please indicate primary insurance: | | | | | |
| Subscriber's name: | Birth date: | Group no.: | Policy no.: | Co-payment: | |
| Patient's relationship to subscriber: | | | | | |
| Name of secondary insurance (if applicable): | Subscriber's name: | | Group no.: | Policy no.: | |
| **IN CASE OF EMERGENCY** | | | | | |
| Name of person we should contact: | 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 also authorize Craig Feuerman, MD PC or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date