



## REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First name:		Middle:			
Age today:		Birth date:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status:	
Street address:			Social Security number:			Home phone number: (    )	
P.O. Box:		City:			State:		Zip code:
Occupation:		Employer:			Work phone number: (    )		
Referred to this office by:							
<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:							

<b>PAYMENT INFORMATION</b>							
(Please give your Medicare/Insurance card to the receptionist.)							
Person responsible for bill (if not listed above):		Birth date: / /		Address (if different):			Home phone number: (    )
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Occupation:			
Employer:		Employer address:			Employer phone number: (    )		
Is this patient covered by Medicare?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medicare #			
Insurance Information		Name of Insurance Co.:					
Subscriber's name:		Subscriber's S.S. number:		Birth date: / /	Group number:	Policy number:	State:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.: (    )	Work phone number: (    )
The above information is true to the best of my knowledge. I understand that I am financially responsible for all office visits. I also authorize Southern Maine Integrative Health Center, LLC to release any information required to process my insurance claims, if I choose to file them.							
Patient/Guardian signature						Date	