SOUTHERN MAINE INTEGRATIVE HEALTH CENTER, LLC

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician: Phone Number:

PATIENT INFORMATION

Patient's last name:		First name:		Middle:	
Birthdate:	Age today:	Sex: ❑ M ❑ F	Marital Status:		
Street address:		Social Security number:		Home phone number: ( )	
P.O. Box:	City:		State:		Zip code:
Occupation:	Employer:			Cell phone number: ( )	
Referred to this office by:		Email address: (for appt. reminder)			

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

PAYMENT INFORMATION

(Please give your 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? ❑ Yes ❑ No Occupation:

Employer:		Employer address:	Employer phone number: ( )

Is this patient covered by Medicare? ❑ Yes ❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

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*