REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Maiden Name:	Race:	Ethnicity ❑ Hispanic/Latino ❑Not Hispanic/Latino ❑ Refused	Birth date: / /	Age:	Sex: ❑ M ❑ F

Social Security #	Address:	Home # : ( ) Cell #: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

Preferred Pharmacy(w/address):

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

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

Other family members seen here:

Email address for portal registration:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber Name:	Birth date: / /	Address (if different):	Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Insurance Carrier:

Insurance Address:	Insurance Phone #: ( )	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

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 #: ( )	Work phone #: ( )

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 Austin Primary Care Physicians or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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