Primary Care Associates of LVPG

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Patient's last name: First:		Middle:	Marital status:
Address:			
Social Security no.:	Home phone no.: Cell phone no.:		Spouse's name & Phone #:
Occupation:	Employer:		Employer phone no.:
Race: Ethnicity: Preferred Language:			
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:
Please indicate primary insurance:			
Subscriber's name:	Subscriber's S.S. no.:	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.:	
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of friend or relative (not living at same address):	Relationship to patient:	Phone no.:	Work phone no.: [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 Primary Care Associates of LVPG or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date