Total Health Center Inc.

REGISTRATION FORM

Today's Date:			Primary Care Physician:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:		Marital status:	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?		Birth date:	Age:	Gender: ☐ M ☐ F
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
ACCOUNT LIABILITY INFORMATION					
Person responsible for bill:		Address (if different):	Home phone no.:		
Relationship to patient:		Birth date:			
Employer:		Employer address:	Employer phone no.:		
INSURANCE INFORMATION					
(Please give your insurance card (s) to the receptionist.)					
Name of 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:	Subscriber's Birth Date:				

Do you have a Medicaid Policy?

☐ Yes ☐ No

Total Health Center Inc. is not a participant with Medicaid insurance. You are acknowledging that you are not covered by any Medicaid Insurance. Medicaid guideline states that if after the date of service (s) it is determined you are on a Medicaid policy that you will be financially responsible for the charges incurred.

_____ (signature required)

IN CASE OF EMERGENCY			
Name of local friend or relative:	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 understand that I am financially responsible for any balance. I also authorize Total Health Center Inc. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date