

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ Sex: M / F (circle one) Married/Single/Divorced/Widow

Address: _____

Home Phone: (____) _____ City/State _____ Zip _____

Employer Name: _____ Phone: (____) _____ ext _____

Employer Address: _____

Street

City/State/Zip

Primary Care Physician: _____

E-Mail Address: _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (Please Check) self spouse parent Date of Birth ____/____/____

Address: _____

Street

City/State/Zip

Employer Name: _____ Phone: (____) _____ ext _____

Employer Address: _____

Street

City/State/Zip

Who to call for an emergency: Name: _____

Address: _____ Relationship: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Primary Insurance Information

Plan Name: _____ ID # _____

Address: _____ Group # _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Secondary Insurance Information

Plan Name: _____ ID # _____

Address: _____ Group # _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Michael F. Pingree, M.D. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____