### Phoenix HealthCare Clinic

# Registration Form

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| **(Please Print)** |
| PATIENT INFORMATION |
| Last name: First: MI: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle)S / M / Div. / Sep / W |
| Birth date: M/D/Y | Age | SSN (Required) | Sex ❑ M ❑ F |
| Address: | City/State | Zip: |
| Home Phone ( ) | Cell Phone ( ) Work Phone ( ) |
| Communication Preference❑ Home ❑ Work ❑Cell ❑Do Not Call | Advanced Directive Type: ❑ No Advanced Directives ❑ Living Will ❑Trust ❑ Durable Power of Attorney ❑ Do Not Resuscitate Date last Reviewed |
| Occupation: | Employer and Address: | Employer phone number:( ) |
| Confidential Communication :  Home  Work Cell  Mail  Email | Messages may be left with Name: |
| **Referred to clinic by (please check one box):** ❑Healthcare Provider ❑ Insurance ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work❑Mailing ❑ Flyer ❑ Brochure ❑ Magazine/Newspaper ❑ Self ❑ Other |
| Is patient covered by insurance? ❑ Yes ❑ No |
| INSURANCE INFORMATION |
| **(Please give your insurance card and driver’s license to the receptionist for copying)** |
| Person responsible for bill: | Birth date: | Address (if different):  | Home phone number:( ) |
| Occupation: | Employer/Address/City/Zip: Employer phone number ( ) |
| Primary insurance ❑ Medicaid ❑ Medicare ❑ Tricare ❑ Deductible ❑ Co-Pay |
| Subscriber’s name: Subscriber’s SSN Subscriber’s Birth Date |
| Group number: | Policy number: | Co-payment: $ Deductable:$ |
| Patient’s relationship to subscriber:❑ Self ❑Spouse ❑Child |
| Secondary insurance (if applicable): ❑ Medicare ❑ Tricare ❑ Deductible ❑ Co-Pay |
| Subscriber’s name: | Group number: | Policy number: |
| IN CASE OF EMERGENCY |
| Name of friend or relative (not at same address): | Relationship  | Home Phone ( )Work Phone ( )Cell Phone ( ) |
| Address | City/Zip  | Email Address: |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Phoenix Healthcare Clinic or insurance company to release any information required to process my claims. |
| Patient/Guardian Signature | Date |