### 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 | | | | |