

**PREFERRED PROFESSIONAL MEDICAL CARE
REGISTRATION FORM**

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle) S / M / D / Sep / W
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security no.:		Home phone no.: ()	
P.O. Box:		City:		State:		ZIP code:	
Occupation:			Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):					<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Website	<input type="checkbox"/> Other		
Other family members seen here:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance							
Group no:			Policy no:				
Subscriber's name:	Subscriber's SSN:		Birth date: / /	Group no:		Policy no:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no:		Policy no:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other	
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			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 PPM or insurance company to release any information required to process my claims.							
Patient/Guardian signature						Date	