New Patient Registration Form

PLEASE PRINT **DATE**_____

How did you learn about our practice? Physician _____

Relative_____ Friend_____ Website_____ Phone book_____ Newspaper_____ Other _____

Patient's Full Name _____ Age _____

Home Address _____

City _____ **State** ___ **Zip** _____

Home Phone Number _____ Mobile Phone Number _____

Emergency Contact Person _____ Emergency Phone Number _____

Patient's Email Address _____

Patient's Date of Birth _____ **Social Security Number** _____

Sex M ___ F ____

Marital Status (circle one) Single Married Widowed Divorced

Race (optional) Caucasian __ Hispanic __ African American __ Asian__ Other__

Patient's Employer _____

If not employed, is patient… Retired? __ Student? __ Homemaker? __ Unemployed? __

Patient Employer Address _____

City _____ State _____ Zip _____

Employer Phone Number _____ Extension _____

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Responsible Party Information

Who is financially responsible for the account? (Note: The responsible party can never be a child.)

Is the Responsible Party the same as the patient information? Yes___ No__ (if no, please fill in the information below)

Name _____

Address _____ **City** _____ **State** ___ **Zip** ____

Phone Number _____

Email Address _____

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name _____

Patient/Guardian Address _____ City _____ State ____ Zip ____

Patient/Guardian Phone Number _____

Patient/Guardian Email Address _____

I acknowledge the above information is correct and I accept financial responsibility for any services offered for my dependent or myself.

Signature _____ **Date** _____

St Luke's PHYSICIAN GROUP

New Patient Registration Form

Primary Insurance Information

Name of Primary Insurance _____

Primary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Is the Patient the subscriber for the Primary Insurance? Yes ___ No ___
(If no, please complete this section.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M ___ F ___
Subscriber Social Security Number _____**Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

Secondary Insurance Information (if applicable)

Name of Secondary Insurance _____

Secondary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____
Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Social Security Number _____ **Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

St Luke's PHYSICIAN GROUP

New Patient Registration Form

Tertiary Insurance Information (if applicable)

Name of Tertiary Insurance _____

Tertiary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Social Security Number _____ **Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____