### Emir Primary Care

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **(Please Print)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | First: | | | | | | | | | | | Middle: | | | | | | Mr.  Mrs. | | | Miss  Ms. | | | Marital status: | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | Single  Mar  Div  Sep  Wid | | | | | | | | | | | | | | | | |
| Is this your legal name? | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | | Birth date: | | | | | | Age: | | | Sex: | | | |
| Yes | | No | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | |  | | | M | | F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | Cell Phone no.: | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | (     ) | | | | | | | | | |
| P.O. box: | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | ZIP Code: | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |
| Occupation: | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (     ) | | | | | | | | | | |
| How did you hear about Emir Primary Care? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Email Address:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (If you have your insurance card, please give it to the receptionist and **skip** this section.) If not filing insurance **skip** this entire section | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | (     ) | | | | | | | | | | |
| Is this person a patient here? | | | | | | Yes | | | | | | | | | No | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Occupation: | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | |
|  | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | (     ) | | | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | | | | Yes | | | | | | | | No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | | Medicare | | | | | | | | | | | | | | Medicaid | | | | | | | United Healthcare | | | | | | | | | | | Aetna | | | | | | | Blue Cross | | | | |
| Tricare | | | | Beechstreet | | | | | | | | | | | | Other | | | | | |  | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | |
| Subscriber’s name: | | | | | | | Subscriber’s S.S. no: | | | | | | | | | | | | | | | | Birth date: | | | | | | | Group no.: | | | | | | | | | | Policy no.: | | | | | | | | Co-payment: | | |
|  | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | | | $ | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | Self | | | | | | | | Spouse | | | | | | Child | | | | Other | | | | | |  | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | Policy no.: | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | Self | | | | | | | Spouse | | | | | | Child | | | | 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 **Emir Primary Care** or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | |  |