REGISTRATION FORM

(Please Print)

Today's date:	**Email Address:**

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Home Phone:		Cell phone: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD)

Responsible Party (if other than patient)

Name:	Relationship to Patient:	Address/City/State/Zip Code:	Phone no.: ( )

Name of Primary insurance:

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:	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 North Dallas Primary Care Doctors, PLLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*