REGISTRATION FORM

(Please Print)

Today's date:	**Pharmacy:**

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status (circle one) ❑ Single / ❑ Mar / ❑ Div / ❑ Sep / ❑ Wid

Former Name	Social Security no:	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.			
❑ Family	❑ Friend	❑ Close to home/work	❑ Website	❑ Other

Email Address :

Primary Care Physician:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary insurance	❑ Medicare	❑ BCBS	❑ Aetna	❑ Humana	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Other

Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Other

IN CASE OF EMERGENCY

Name of relative (in case of an emergency situation):	Relationship to patient:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Charlotte Hearts. I understand that I am financially responsible for any balance. I also authorize Charlotte Hearts or insurance company to release any information required to process my claims. I authorize the use of my signature on all insurance submissions.

Patient signature *Date*