Donaldson Medical Clinic
REGISTRATION FORM

| | | | | | |
|---|---|---|---|---|---|
| (Please Print) | | | | | |
| Today's date: | | | PCP: | | |
| PATIENT INFORMATION | | | | | |
| Patient's last name: | First: | Middle: | Mr.<br>Mrs. | Miss<br>Ms. | Marital status (circle one) |
| | | | | | 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.: | | Home phone no.: | |
| | | | | ( ) | |
| P.O. box: | City: | | State: | ZIP Code: | |
| | | | | | |
| Email: | Pharmacy: | | Do you want access online to your account? | Yes or No | |
| Occupation: | | Employer: | | Employer phone no.: | |
| | | | | ( ) | |
| Chose clinic because/Referred to clinic by :Name: | Dr. | | | | |
| 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? | Yes | No | | | |
| Occupation: | Employer: | | Employer address: | Employer phone no.: | |
| | | | | ( ) | |
| Is this patient covered by insurance? | Yes | | No | | |
| Please indicate primary insurance | | United Health | Medicare | Medicaid | Cigna |
| Blue Cross | Assurant | UMR | Other: | 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 Donaldson Medical Clinic or insurance company to release any information required to process my claims. | | | | | |
| | | | | | |
| | **Patient/ Guardian signature** | | **Date** | | |