Prestige Medical Group

REGISTRATION FORM

Last Doctor seen: Today's date:

PATIENT INFORMATION

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?	Preferred Contact method:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address / PO Box:		Social Security #	Home phone # ( )			
City:	State:	ZIP Code:	Cell Phone # ( )			
Email:	Occupation / Employer:		Employer phone # ( )			
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:						
Race:	Ethnicity	Preferred Language:				

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)*

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Blue Cross - PPO	❑ Blue Cross HMO	❑ Blue Cross POS	❑ Medicare	❑ Medicaid
❑ United Healthcare	❑ Tricare	❑ Coventry	❑ Welfare *(Please provide coupon)*	❑ 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 : ( )	Work phone: ( )

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 Internal Medicine Associates of Jasper, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*