# Kissimmee Primary Care
## REGISTRATION FORM

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|---|---|---|---|---|---|
| Today's Date: | | | PCP: [PCP] | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: [Last Name] | First: [First Name] | Middle: [Initial] | [Choose an item] | al status: | [Choose an item] |
| Is this your legal name? ○ Yes ○ No | If not, what is your legal name? [Legal Name] | Former name: [Former Name] | Birth date: | Age: [Age] | Sex: ○ M ○ F |
| Address: [Address/ P.O Box, City, ST ZIP Code] | | | | | |
| Social Security no.: [SS#] | Home phone no.: [Phone] | Cell phone no.: [Phone] | | | |
| Occupation: [Occupation] | Employer: [Employer] | Employer phone no.: [Phone] | | | |
| Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item] | | | | | |
| Other family members seen here: [Other patients] | | | | | |
| **INSURANCE INFORMATION** | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: [Responsible party] | Birth date: | Address (if different): [Address] | Home phone no.: [Phone] | | |
| Is this person a patient here? ○ Yes ○ No | | Is this patient covered by insurance? | ○ Yes ○ No | | |
| Occupation: [Occupation] | Employer: [Employer] | Employer address: [Address] | Employer phone no.: [Phone] | | |
| Please indicate primary insurance: [Choose an item] \| Other: [Other insurance] | | | | | |
| Subscriber's name: [Name] | Subscriber's S.S. no.: [SS#] | Birth date: | Group no.: [Group #] | Policy no.: [Policy #] | Co-payment: $[Co-pay] |
| Patient's relationship to subscriber: [Choose an item] \| Other: [Relationship to subscriber] | | | | | |
| Name of secondary insurance (if applicable): [Secondary Insurance] | Subscriber's name: [Name] | | Group no.: [Group #] | Policy no.: [Policy #] | |
| Patient's relationship to subscriber: [Choose an item] \| Other: [Relationship to subscriber] | | | | | |
| **IN CASE OF EMERGENCY** | | | | | |
| Name of local friend or relative (not living at same address): [Friend or relative name] | Relationship to patient: [Relationship] | Home phone no.: [Phone] | Work phone no.: [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 Kissimmee Primary Care or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date