



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

## REGISTRATION FORM

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )		
P.O. box:		City:		State:		ZIP Code:	
Cell Phone: ( )		Employer:			Employer phone no.: ( )		
<b>Referred to clinic by (please check one box):</b>				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Cigna		<input type="checkbox"/> Citrus H/C	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medipass	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> United health Care		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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 [Name of Practice] or insurance company to release any information required to process my claims.							
_____ Patient/Guardian signature				_____ Date			