PATIENT REGISTRATION FORM

Today's Date:	PCP:	Pharmacy:

PATIENT INFORMATION

Reason for visit:			
Last Name:	First Name:		Marital Status:
DOB:	AGE:	SEX:	
Address:	City/State:	Zip Code:	
SSN:	Home Phone:		Cell Phone:
Email	Language Preferred:		Race/Ethnicity:

INSURANCE INFORMATION (Please present your insurance card when you check-in for your appointment.)			
Please indicate primary insurance:		Member ID #	Co-Payment:
Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:	Relationship to Subscriber:
Name of Secondary Insurance (if applicable):		Subscriber's Name:	Relationship to Subscriber:

IN CASE OF EMERGENCY			
Name of a 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 Tristan Medical Care Centers or insurance company to release any information to process my claims.

_____ _____

Patient/ Guardian Signature Date