STONE CREEK FAMILY MEDICINE
REGISTRATION FORM

Date:	**Last PCP's**:	PCP Phone:

PATIENT INFORMATION

Patient's Last Name: Patient's First Name:	Patient's Birthdate: Relationship Status: Single ☐ Mar ☐ Div ☐ Sep ☐		
Street Address:	City:	State:	Zip:
Home Phone: ☐	Preferred Pharmacy:		
Cell Phone: ☐	Pharmacy Phone:		
Email Address: ☐			

****Please Check each box above which you authorize medical information to be relayed to you**

INSURANCE INFORMATION

Person responsible for bill:

Primary Insurance:	**Secondary Insurance:**
Subscriber's Name:	Subscribers Name:
Subscriber's Birthdate:	Subscribers Birthdate:
Group Number:	Group Number:
Patient's relationship to subscriber: Please check one:	
☐ Self ☐Child ☐Spouse	

IN CASE OF EMERGENCY

Name:		
Street Address:		
City:	State:	Zip:
Phone Number:		
Relationship to Patient:		

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

Spouse:
My Children:
Other:

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 my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Signature:_____ Date: _____