



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

REGISTRATION FORM

(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Marital status (circle one)			
Single / Mar / Div / Sep / Wid			
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No		/ /
			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 no:	Employer:	Employer phone no.:	
()		()	
Chose clinic because/Referred to clinic by (please check one box):		<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"/> BC/BS	<input type="checkbox"/> Cigna	<input type="checkbox"/> United Health <input type="checkbox"/> Aetna <input type="checkbox"/> Medicaid
<input type="checkbox"/> Citrus Health	<input type="checkbox"/> Humana	<input type="checkbox"/> Tri Care	<input type="checkbox"/> Medicare <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 Wesley Chapel Internal Medicine & pediatrics or insurance company to release any information required to process my claims.			
Signature: X		Date:	