Hemberg Health Care, LLC

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status: [Choose an item]

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Race: ____American Indian or Alaska Native ____Asian ____Black or African American ____Native Hawaiian or other Pacific Islander ____White ____Other race

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Refuse to report (Our government mandates that we report this information. We do not in any way discriminate.)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Self_____ Spouse_____ | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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):	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 Hemberg Health Care, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature Date