THE DOWNTOWN MEDCENTER

(Downtown Clinic, Inc.)

PATIENT REGISTRATION FORM

(Please print neatly and fill out answers to all questions)

Last Name: ______________________ First Name: ______________________ MI: ________

Social Security Number: ________________ Drivers License Number: ______________ State: ______

Address: ______________________ City: ______________ State: ______ Zip: ______

Mailing Address: (if different from above) ____

Date of Birth: ____________________ Age: ________________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Phone: (H) ________________ (W) ________________ © ________________

Employer: ____

Address: ______________________ City: ______________ State: ______ Zip: ______

Is this visit work related? ☐ No ☐ Yes If yes, explain: ______________________________

How did you learn about us? ____

Name of emergency contact: ______________________ Phone: ________________

Reason for visit: ____

Person responsible for bill: ______________________ Relationship to patient: ______________

Method of payment: ☐ Cash ☐ Check ☐ Credit card ☐ Other: ______________________

INSURANCE INFORMATION (Please present card)

Insurance Company: ____

Subscriber Name: ______________________ Subscriber birth date: ________________

Subscriber Number: ____________ Group Number: ____________ Relationship to subscriber: ☐ Spouse ☐ Child

I acknowledge receipt of medical services and authorize my insurance benefits to be paid directly to the above signed facility or physician. I realize that I am responsible to pay any non covered services. I authorize the release of pertinent medical information concerning any visits to the above named facility or provider to my insurance company.

Payment is due at the time services are rendered. Thank you.

Patient/Legal Guardian Signature: ________________________________ Date: ____________