## Patient Registration Form

Patient Name: Date of Birth: Age:

Full Address:

City: state: zip:

Phone: Home: Work Phone: Cell #:

Social Security #: Sex: ____ Male ____ Female

Marital status: _____ Married ____ Single ___ Widowed _____ Divorced _____ Other

Emergency Contact: Phone:

Relationship:

E-mail address:

Pharmacy Name: Address:

Telephone:

**Primary Medical Insurance:**

Policy Holder Name: Policy Holder SSN: Policy Holder DOB:

Plan Name: Policy #:

Type of Plan: HMO PPO Referral Required: Yes or No

**Secondary Medical Insurance**:

Employer: Occupation:

Employer Address:

Referring Physician: Phone:

Address:

Primary Care MD: Phone:

Address:

Other Physician: Phone:

Address:

Specialty:

Doctor you are here to see: Please circle one **Cliff P. Connery, M.D. OR Faiz Y. Bhora, M.D.**

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Patient Signature: ______________________________________________________Date:_________________