Klamath Family Practice Center, PC

(Please Print)

Patient Registration			**Today's Date:**		
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Widowed

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

Street address:	Social Security no:	Home/Contact phone no: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

GUARANTOR INFORMATION (RESPONSIBLE PARTY)

(Please give your insurance card to the receptionist.)

If patient and guarantor are the same check here: ☐	Relationship to patient:

Person responsible for bill:	Birth date: / /	Address (if different):	Home/Contact phone no: ( )

Social Security no:	Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no:
			( )

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no:	Birth date: / /	Group no:	ID/Policy no:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

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

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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 Klamath Family Practice Center PC or insurance company to release any information required to process my claims and collect balances.

Patient/Guardian signature *Date*

Guarantor signature (if different than patient) *Date*