



REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patients Name: (Last) (First) (Middle)			Mr. Mrs.	Miss Ms	Marital status: (circle one) Single / Mar / Div / Sep / Wid
Birth date:	Age:	Race:	Sex:	Email Address:	
Address:			SSN:	Primary Phone:	
Occupation:		Employer:		Employer phone no.:	
Chose clinic because/referred to clinic by: Dr. / Insurance Plan / Hospital / Family / Friend / Close to home/work / Yellow Pages / Website / Other _____					
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Is this patient covered by Insurance? Yes / No			Please Indicate Primary Insurance:		
Subscribers Name:	Subscribers SSN:	Birth Date:	Policy No.	Group Name:	Group No.
Patients Relationship to Subscriber: Self / Spouse / Child / Other					
Plan Code:	Effective Date:		Expiration Date:		
Name of secondary insurance (if applicable):	Subscribers Name:		Policy No.	Group No.	
Patients Relationship to Subscriber: Self / Spouse / Child / Other					

IN CASE OF EMERGENCY		
Name of local friend or relative:	Relationship to patient:	Phone number:
<p>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 Advanced Wound Care & Hyperbaric Medicine of Michigan or insurance company to release any information required to process my claims.</p>		
Patient/Guardian signature:		Date: