

Signature Medicine - New Patient Registration Form

(Please Print)

PATIENT INFORMATION					
Patient's last name:		First name:		Middle name:	
Mailing address:			City:	State:	ZIP code:
Home phone no.: () -		Cell phone no.: () -		Work phone no.: () -	Patient Email:
Patient Date of Birth:		Patient Age:	Patient Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other	
Social Security no.: - -		Employer Name and Address:			
If patient is a senior with a legal Power of Attorney or a minor, please give POA/guardian/parent names and specify relation to patient:					

IN CASE OF EMERGENCY				
Name of emergency contact person:		Relationship to patient:	Home phone no.: () -	Work phone no.: () -
Mailing address:		City:	State:	ZIP code:

INSURANCE INFORMATION					
Name of primary insurance:		Policy subscriber's name, if not patient:		Policy subscriber's date of birth:	
Policy Number:		Policy Effective Date:			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:					
Name of secondary insurance (if applicable):		Policy subscriber's name, if not patient:		Policy subscriber's date of birth:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:					

RESPONSIBLE PARTY (GUARANTOR)					
The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.					
Guarantor's last name:		Guarantor's first name:		Guarantor's middle name:	
Guarantor's mailing address, if different from patient:			City:	State:	ZIP code:
Guarantor's phone number: () -		Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security No.: - -	

OTHER INFORMATION			
Pharmacy name:		Pharmacy location:	Pharmacy phone no.: () -
How did you hear about this office, or who referred you here?			
May we notify you of appt./test results at the e-mail address listed above		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave messages of test results on your answering machine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave voicemail messages of appointments on your answering machine?		May we notify you of appointments at this mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		May we notify you of test results at this mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	