Meeting House Lane Medical Practice, PC
Patient Registration

Patient Information

Date:

Patient Name: (Last) (First) (Middle)			Date of Birth:
Social Security Number:	Marital Status: **S M D W**	Driver's License:	Sex: **M F**
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home Work Other
Primary Care Physician:		Referring Physician:	
Employer Name:	Address:	Business Phone:	Type of Work:
Emergency Contact:	Relationship:	Phone:	
Race:	Preferred Language:	Religion:	

Guarantor Information (Responsible Party, spouse or parent)

(Last) (First) (Middle)		Relationship to Patient:	Date of Birth:
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home Work Other
Social Security Number:		Drivers License:	
Employer Name:	Address:	Business Phone:	Type of Work:

Insurance Information

Primary Insurance Name:	Claims Address: (City) (State) (Zip)	Phone:
Policy Holder (Name):	Policy Number Group Number: Policyholder Date of Birth:	

Secondary Insurance Name:	Claims Address: (City) (State) (Zip)	Phone:
Policy Holder (Name):	Policy Number: Group Number: Policyholder Date of Birth:	

I hereby authorize Meeting House Lane Medical Practice, PC for treatment and the release of any medical information to the insurance carriers to process claims. I also authorize all payments for medical services to the patient to be assigned to the supplier of services. I understand that I am responsible for all amounts not covered by my insurance company, including deductibles and co-insurance.

X_____

Patient or Responsible Party's Signature **Date**