PATIENT REGISTRATION FORM

TristanMedical CARE CENTERS

Today's Date:	PCP:	Pharmacy:

PATIENT INFORMATION					
Reason for visit:					
Last name:	First Name:		Marital status:		
Is this your legal name? Yes ◯ No ◯	If not, what is your legal name?	Former name:	DOB:	Age:	Sex: Female
Address:					
SSN:	Home Phone:		Cell Phone:		
Email:	Language preferred: English		Race/Ethnicity: Select One		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	DOB:	Address (if different)			
Home Phone:	Is this person a patient here? Yes ◯ No ◯		Is this patient covered by insurance? Yes ◯ No ◯		
Please indicate primary insurance:		Policy			
Subscriber's name:	Subscriber's SSN:	Subscribers DOB:	Group No.:	Policy No.:	Co-Payment:
Patient's relationship to subscriber: Select one		Other:			
Name of secondary/Other insurance (if applicable):	Subscriber's name:		Group No.:	Policy No.:	
Patient's relationship to subscriber: Select one		Other:			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address)	Relationship to patient:	Home Phone:	Work Phone:

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 Tristan Medical Care Center or insurance company to release any information required to process my claims.

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Patient/Guardian signature Date