



PATIENT REGISTRATION FORM

Today's Date:	PCP:	Pharmacy:
---------------	------	-----------

PATIENT INFORMATION

Reason for visit:		
Last Name:	First Name:	Marital Status:
DOB:	AGE:	SEX:
Address:	City/State:	Zip Code:
SSN:	Home Phone:	Cell Phone:
Email	Language Preferred:	Race/Ethnicity:

INSURANCE INFORMATION			
(Please present your insurance card when you check-in for your appointment.)			
Please indicate primary insurance:	Member ID #	Co-Payment:	
Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:	Relationship to Subscriber:
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Relationship to Subscriber:	

IN CASE OF EMERGENCY			
Name of a local friend or relative (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:
<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 Tristan Medical Care Centers or insurance company to release any information to process my claims.</p>			
Patient/ Guardian Signature _____		Date _____	