Care Choice, LLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
	PATIENT'S LEGAL FIRST/MIDDLE/LAST NAME		
	HOME ADDRESS		
	EMAIL ADDRESS		
	HOME PHONE #	**MOBILE PHONE #**	**WORK PHONE #**
	PREFERRED LANGUAGE	**DOB**	**SOCIAL SECURITY #**
	RACE (CIRCLE ONE): **AFRICAN AMERICAN, AMERICAN INDIAN, ASIAN, CAUCASIAN, NATIVE HAWAIINAN/PACIFIC ISLANDER,**	**ETHNICITY (CIRCLE ONE):** **ARAB DESCENT, HISPANIC/LATIONO, OTHER, UNKNOWN, DECLINED TO ANSWER**	
	EMERGENCY CONTACT & RELATIONSHIP		**EMERGENCY PHONE #**
	PHARMACY NAME	**PHARMACY PHONE #**	
FINANCIAL	**PERSON FINANCIALLY RESPONSIBLE IF PATIENT IS UNDER AGE OF 18**		
	LEGAL FIRST/MIDDLE/LAST NAME		
	STREET ADDRESS		
	HOME PHONE #	**DOB**	**SOCIAL SECURITY #**
INSURANCE INFORMATION			
	PRIMARY INSURANCE NAME	**PRIMARY INSURANCE ADDRESS**	
	SUBSCRIBER NAME	**DOB**	**SEX**
	SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**
	SECONDARY INSURANCE NAME	**SECONDARY INSURANCE ADDRESS**	
	SUBSCRIBER NAME	**DOB**	**SEX**
	SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**

I authorize the medical staff and personnel to release my medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

_____ _____

Signature Date

I hereby assign my insurance benefits to be paid directly to Care Choice, LLC. I understand that I am financially responsible for all charges not covered by this assignment.

_____ _____

Signature Date

By signing this form, I hereby consent to treatment by the physicians/practitioners of Care Choice, LLC.

_____ _____

Signature Date