REJUVIMED WELLNESS CENTER

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Separated / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home or Cell Phone.:	Email:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance company: Phone Number:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone Number: ( )	Work phone no.: ( )

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 Rejuvimed Wellness Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*