

PATIENT REGISTRATION FORM

PATIENT'S NAME: _____

Birth Date: _____ Sex: (M) or (F) SS#: _____ Marital Status (circle): Single/Married/Other

Mailing Address: _____ APT Number: _____

City: _____ State: _____ Zip: _____ Employer: _____

Home Phone _____ Cell: _____ Work: _____ Pharmacy: _____

Email: _____ I authorize the leaving of messages about appointments/answers to questions to:

Home Phone Cell Phone Work Phone.

Race: American Indian & Alaskan Native; Asian; Black or African American; Black Hispanic or Latino; Native Hawaiian or Other Pacific Islander; White; White Hispanic or Latino. **Ethnicity:** Hispanic or Latino; Not Hispanic or Latino. **Language Preference:** English; Chinese; French; German; Italian; Japanese; Korean; Portuguese; Russian; Spanish.

EMERGENCY CONTACT: Name: _____ Phone#: _____

If a Student, **PARENTS' NAME:** _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____

Address: _____ City: _____ State: _____ Zip: _____

Member ID#: _____ Insurance Plan Phone # _____ Group # _____ Copay \$ _____

Policy Holder's Name: _____ Policy Holder's Birthday: _____ Relation to Patient: Self/Spouse/Child/Other

Have you told the Insurance Company you have **changed your PCP to Dr. Clarke?** Yes or No or N/A

SECONDARY INSURANCE: _____

Address: _____ City: _____ State: _____ Zip: _____

Member ID#: _____ Insurance Plan Phone # _____ Group # _____ Copay \$ _____

Policy Holder's Name: _____ Policy Holder's Birthday: _____ Relation to Patient: Self/Spouse/Child/Other

By my signature below I consent to treatment of myself / my minor child by SheDoc, PLLC. I authorize the release of any medical or other information necessary for treatment / Public Health and payment of government or third party benefits to SheDoc, PLLC or her providers. I authorize payment of medical benefits directly to SheDoc, PLLC or her providers. I understand I am responsible for what my insurance company does not cover. In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees determined and awarded by the court. If this account is referred for collection, I / we agree to pay collection fees on the balance owing. If legal action is deemed necessary, I / we agree to pay reasonable attorney's fees and court costs in addition to the above costs.

Signature: _____ Date: ____/____/____

(Patient; Parent, if minor; or Guardian)