DAYONE FAMILY HEALTHCARE
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) S / M / D / Sep / W		
Street address:	City:	State: ZIP Code:	Date of Birth: / /	Age:	Sex: M F
Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	May we contact you at work? Yes No		
Employer:	Occupation:	Shift:	Email address:		
Social Security #	Spouse's Name: Date of Birth:		Are they authorized to receive your medical information? Yes No		
How did you hear about our office? (please check one box):	❑ Dr.	❑ Insurance	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Phonebook	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LISCENSE/ID AT EVERY VISIT)

Guarantor (Person responsible for bill)	Birth date: / /	Address (if different then patient):	Home phone: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance:	❑ Medicare	❑ Cigna	❑ Blue Cross Blue Shield	❑ Blue Care Network	❑ Cofinity (Aetna/PPOM)
❑ Beechstreet	❑ First Health	❑ United Healthcare	❑ Medicaid/ HMO Medicaid	❑ Other	

Subscriber's name:	Subscriber's SS #	Date of Birth: / /	Group #	Policy #	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of 2ndry insurance (if applicable):	Subscriber's name:		Group #	Policy #	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone: ( )	Cell 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 DayOne Family Healthcare or my insurance company to release any information required to process my claims.

Patient/Guardian signature Date