Main Street Family Practice, P.C.

660 South Main Street ▪ P.O. Box 2818 ▪ Florence, AZ 85132
Telephone 520.868.1400 Fax 520.868.1500

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Single ☐ Married ☐ Partner ☐ Widow

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex ☐ M ☐ F

Mailing Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

Street Address (If Different)	City	State	ZIP Code	Cell Phone (Text Conf Y / N) ( )	Email (if you want email confirmation)

Occupation	Employer	Employer Phone No. ( )

Why did you choose Main Street Family Practice (Please check one box) ☐ Dr. ☐ School ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Newspaper ☐ Other

If Minor, Parents Name and Phone Number Father_____ Mother_____ Phone Number:_____	Spouse/Partner Name:_____ Spouse/Partner Work Phone: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. ( )
Is this person a patient here?	☐ Yes ☐ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No Type of Insurance: HMO PPO Self (Circle One)

Please indicate primary insurance ☐ United Healthcare ☐ BlueCross/BlueShield ☐ PacifiCare ☐ Health Net ☐ Medicare
☐ University Family Care ☐ Mercy Care ☐ Administrative Enterprises ☐ CIGNA ☐ Tri-Care Other:
☐ Great West ☐ AETNA ☐ Pinal County Long Term Care ☐ CMDP ☐ Humana

Subscriber's Name	Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary 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 No. ( )	Work Phone No. ( )

The information I provided above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Main Street Family Practice. I authorize Main Street Family Practice or insurance company to release any medical or personal information required to process my claims. I authorize the emergency contact listed above to receive or discuss medical information in the event of an emergency. I have read and agree to the terms of the Main Street Family Practice Notice of Privacy Practices, Financial Responsibilities and Billing Policy and No Show Policy, These authorizations will remain in effect indefinitely unless I revoke it in writing. A photocopy or fax of this signed form is considered as valid as the original.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Revised 7/09