

VOILA LA FAMILIA REGISTRATION FORM

Today's Date:				PCP:	
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Marital status:	
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Former name:		Birth date:	Age: Sex: <input type="radio"/> M <input type="radio"/> F
Address:					
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
Chose clinic because/referred to clinic by (Please choose one option): <input type="radio"/> [Doctor's name] <input type="radio"/> [Choose an item]					
Other family members seen here:					
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? <input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance? <input type="radio"/> Yes <input type="radio"/> No				
Occupation:	Employer:	Employer address:		Employer phone no.:	
Please indicate primary insurance: [Choose an item] Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:			Other:		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:			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 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 that is not covered by my insurance plan. I also authorize VOILA LA FAMILIA or insurance company to release any information required to process my claims. I also authorize Voila La Familia to bill and accept assignment of Benefits from my insurance carrier.					
Patient/Guardian signature			Date		