### Shaw Family Medical

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | |
| Today’s Date: | | | | | | | | Previous Physician/Provider: | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | |
| Last name: | | First: | | | Middle: | ❑ Mr.  ❑ Mrs. | | ❑ Miss  ❑ Ms. | | Marital status (circle one) | | | | |
|  | | | | | | Single / Mar / Div / Sep / Wid | | | | |
| Is this your legal name? | | If not, what is your legal name? | | | (Former name): | | | Birth date: | | | Age: | | Sex: | |
| ❑ Yes | ❑ No |  | | |  | | | / / | | |  | | ❑ M | ❑ F |
| Social Security no.: | | Home phone: Cell phone: Permission to Text? | | | | | Email address for patient portal registration: | | | | | | | |
|  | | ( ) ( ) Yes \_\_\_\_\_ No\_\_\_\_\_\_ | | | | |  | | | | | | | |
| Mailing Address | | Physical address if different from Mailing | | | | | State: | ZIP Code: | | | | | | |
|  | |  | | | | |  |  | | | | | | |
| Occupation: | | Employer: | | | | | | | | | | Employer phone no.: | | |
|  | |  | | | | | | | | | | ( ) | | |
| Preferred Pharmacy Name: | | | | Preferred Pharmacy Phone Number: | |  | | Preferred Pharmacy Location: | | | | Permission to retrieve pharmacy history: Yes No | | |
| Other family members seen here: | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | |
| Person responsible for bill: | | Birth date: | | | Address (if different): | | | | | | | Phone no: (if different from listed above) | | |
| Self/Employer/Workman’s Comp | | / / | | |  | | | | | | | ( ) | | |
| Is this patient covered by insurance? | | ❑Yes | | ❑ No |  | | | | | | | | | |
| Please indicate primary insurance | | ❑ Medicare | | | ❑ MS Medicaid Full | ❑ MS Medicaid Magnolia Health Plan | | ❑ MS Medicaid United Health | | | | ❑ Blue Cross Blue Shield MS  (State Employee) | | |
| ❑ Tricare | ❑ Cigna | ❑ United Health Care | | | ❑ Other | | ❑ Self-Pay/ No Insurance | | | | |  | | |
| Name of secondary insurance (if applicable): | | | Subscriber’s name: | | | | | Group no.: | | | | Policy no.: | | |
|  | | |  | | | | |  | | | |  | | |
| 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 above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Shaw Family Medical or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | |
|  |  | | | | | | |  |  | | | | |  |
|  | Patient/Guardian signature | | | | | | |  | Date | | | | |  |