### Shaw Family Medical

# REGISTRATION FORM

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| --- |
| (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 |  |