REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST	MI	☐ DR. ☐ MR. ☐ MS. ☐ MRS. ☐ MISS

DATE OF BIRTH	AGE	RACE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W ☐ SEP

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

EMAIL ADDRESS

PATIENT'S OCCUPATION	EMPLOYER	EMPLOYER PHONE ( )

SPOUSE'S LAST NAME	FIRST	MI	☐ DR. ☐ MR. ☐ MS. ☐ MRS. ☐ MISS

SPOUSE'S OCCUPATION	EMPLOYER	EMPLOYER PHONE ( )

WHY DID YOU CHOOSE OUR PRACTICE? (PLEASE CHECK ALL THAT APPLY)
☐ INSURANCE PLAN ☐ FAMILY ☐ FRIEND ☐ INTERNET ☐ YELLOW PAGES ☐ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY #	GROUP #

SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE	POLICY #	GROUP #

SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY CARE PHYSICIAN

LAST NAME	FIRST	MI	SPECIALTY

STREET SDDRESS	CITY	STATE	ZIP CODE	OFFICE PHONE ( )

REFERRING PHYSICIAN

LAST NAME	FIRST	MI	SPECIALTY

STREET ADDRESS	CITY	STATE	ZZIP CODE	OFFICE PHONE ( )

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT	HOME PHONE ( )	WORK PHONE ( )

PHARMACY

PHARMACY NAME (FIRST CHOICE)	LOCATION	PHONE NUMBER ( )
PHARMACY NAME (SECOND CHOICE)	LOCATION	PHONE NUMBER ( )

CERTIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vantage Health, LLC or insurance company to release any information required to process my claims.

X		
	PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)	**DATE OF SIGNATURE**
	PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)	**RELATIONSHIP IF OTHER THAN PATIENT**