LivingWell Primary Care
...We Focus on Prevention

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	M.I.:
Marital Status (circle one) ☐Single ☐Widowed ☐Divorced ☐Married ☐Separated	☐Mr. ☐Miss ☐Mrs. ☐Ms.	

Date of Birth:	Age:	Social Security Number:	
Street Address:	City:	State:	Zip:
P.O. Box:	Phone Number:	Email:	
Occupation:	Employer:	Employer Phone Number:	
Please indicate how you were referred to this office:			

INSURANCE INFORMATION

Insured:		Date of birth:	
Address (if different):		Home Phone:	
Occupation:	Employer:	Employer Address:	Employer Phone Number:
Please indicate Primary Insurance Name:			

Subscriber's name:	Subscriber's SSN:	Subscriber's DOB:	Policy Number: Group Number:	Copay:
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other
Name of Secondary Insurance (if applicable):	Subscribers Name:	Policy Number:	Group Number:	
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:	Work or cell:

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 LivingWell Primary Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	*Date:*