PATIENT REGISTRATION FORM

PLEASE NOTE: PAYMENT IS DUE AT TIME OF SERVICE

If you have questions or require help filling out this form, please ask a staff member. Return it to the front desk conciegre when you are finished along with your insurance card and photo identification.

PATIENT DEMOGRAPHICS

Last Name	First Name	M.I.
Date of Birth	Social Security Number	Gender (circle one) Male Female

Email Address	
Marital Status	Preferred Language
Employer	Occupation
Parent or Guardian (If Applicable)	School (If Student)

CURRENT ADDRESS

Street Address	City	State	Zip
Home Phone	Cell Phone		
How did you hear about Lindo Family Health & Wellness Care?			

BILLING ADDRESS (If Different Than Current Address)

Date of Birth	City	State	Zip

INSURANCE STATUS

If no insurance information is obtained, payment will be due at time services are rendered.

POLICY HOLDER INFORMATION

Last Name	First Name	M.I.
Date of Birth	Relationship to Patient	Policy ID Number
Employer		
Social Security Number		Gender (circle one) Male Female

POLICY HOLDER'S BILLING INFORMATION

Street Address	City	State	Zip

POLICY HOLDER'S INSURANCE INFORMATION

Insurance Carrier	Insurance Co Phone		
Group Number	Policy Number		
Insurance Co. Street Address	City	State	Zip

Patient's Signature

(Parent/Guardian's Signature if patient is under 18)

Date