Michigan Primary Care, PLLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LEGAL FIRST/MIDDLE/LAST NAME		
HOME ADDRESS		
EMAIL ADDRESS		
HOME PHONE #	**MOBILE PHONE #**	**WORK PHONE #**
PREFERRED LANGUAGE	**DOB**	**SOCIAL SECURITY #**
RACE (CIRCLE ONE): **AFRICAN AMERICAN, AMERICAN INDIAN, ASIAN, CAUCASIAN, NATIVE HAWAIINAN/PACIFIC ISLANDER, OTHER, UNKNOWN, DECLINE TO**	**ETHNICITY (CIRCLE ONE):** **ARAB DESCENT, HISPANIC/LATIONO, OTHER, UNKNOWN, DECLINED TO ANSWER**	
EMERGENCY CONTACT & RELATIONSHIP		**EMERGENCY PHONE #**
PHARMACY NAME	**PHARMACY PHONE #**	

FINANCIAL

PERSON FINANCIALLY RESPONSIBLE IF PATIENT IS UNDER AGE OF 18		
LEGAL FIRST/MIDDLE/LAST NAME		
STREET ADDRESS		
HOME PHONE #	**DOB**	**SOCIAL SECURITY #**

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	**PRIMARY INSURANCE ADDRESS**	
SUBSCRIBER NAME	**DOB**	**SEX**
SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**
SECONDARY INSURANCE NAME	**SECONDARY INSURANCE ADDRESS**	
SUBSCRIBER NAME	**DOB**	**SEX**
SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**

I authorize the medical staff and personnel to release my medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

_____ _____
Signature Date

I hereby assign my insurance benefits to be paid directly to Michigan Primary Care PLLC. I understand that I am financially responsible for all charges not covered by this assignment.

_____ _____
Signature Date

By signing this form, I hereby consent to treatment by the physicians/practitioners of Michigan Primary Care, PLLC.

_____ _____
Signature Date