THE ENDOCRINE CLINIC

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Patient Registration Information

Date: _____ **Referred By:** _____

Patient Name: _____
Last *First* *Middle Initial*

Address: _____

_____
City *State* *Zip*

Home Phone: _____ **S.S.#:** _____

Cell Phone: _____ **D.O.B:** _____

Work Phone: _____ **Age:** _____

Alternate Phone: _____ **Race:** □Caucasian □Hispanic
Someone that is not living with you □African American □ Other

□ **Male** □ **Female** **Ethnicity:** □Hispanic □Non-Hispanic

Marital Status: □ Single □ Married □ Other _____ □Declined

Email: _____ **Preferred language:** _____

Occupation: _____ **How Long:** _____

Employer: _____ **Phone:** _____

Address: _____

_____
City *State* *Zip*

Emergency Contact: _____

Relationship: _____ **Phone:** _____

Insured's Information

Mandatory: You MUST fill out your spouse's information if you are covered under their insurance policy

Insurance: _____

Address: _____

_____
City *State* *Zip*

Insured's Name: _____ **Relationship:** _____

S.S.#: _____ **Date of Birth:** _____

Policy #: _____ **Group #:** _____

Insured's Employer: _____

Address: _____

_____
City *State* *Zip*

Please list all physicians you are currently seeing so that we are able to include all in your care plan:

Primary Care Physician: _____
Specialty Care Physician: _____
Specialty Care Physician: _____
Specialty Care Physician: _____

* I request payment of authorized benefits be made either to me or on my behalf to The Endocrine Clinic, P.C. for any and all services rendered to me. I authorize The Endocrine Clinic, P.C. holder of medical information about me to be released to my insurance company and/or its agents any information needed to determine these benefits payable for related services.

* I understand that I am responsible for payment for all services provided to me by The Endocrine Clinic. P.C.

Signature: _____ Date: _____

Witness: _____ *If unable to sign* *Relationship* _____