veriMED Health Group
Plant City

REGISTRATION FORM

Thank you for choosing our health care team! We strive to provide you with the best possible health care. To help us meet all your health care needs, please fill out this form completely. If you have any questions or need assistance, we will be happy to help you.

Today's date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Date of Birth:	Age:	Sex:	Social Security no.:	Home Phone:	Ethnicity:
/ /		❑ M ❑F		( )	W B H Asian Other

Street address:			
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	❑ Hospital
Other family members seen here:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑[Insurance]	❑[Insurance]	❑[Insurance]	❑[Insurance]	❑[Insurance]
❑[Insurance]	❑[Insurance]	❑[Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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 no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *veriMEDHealth Group–Plant City* or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*