Phoenix HealthCare Clinic
Registration Form
(Please Print)

PATIENT INFORMATION					
Last name: First: MI:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle) S / M / Div. / Sep / W
Birth date: M/D/Y	Age	SSN (Required)			Sex ❑ M ❑ F
Address:	City/State				Zip:
Home Phone ( )	Cell Phone ( )		Work Phone ( )		
Communication Preference ❑ Home ❑ Work ❑Cell ❑Do Not Call	Advanced Directive Type: ❑ No Advanced Directives ❑ Living Will ❑Trust ❑ Durable Power of Attorney ❑ Do Not Resuscitate Date last Reviewed				
Occupation:	Employer and Address:				Employer phone number: ( )
Confidential Communication : □ Home □ Work □Cell □ Mail □ Email					Messages may be left with Name:
Referred to clinic by (please check one box): ❑Healthcare Provider ❑ Insurance ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑Mailing ❑ Flyer ❑ Brochure ❑ Magazine/Newspaper ❑ Self ❑ Other					
Is patient covered by insurance? ❑ Yes ❑ No					

INSURANCE INFORMATION			
(Please give your insurance card and driver's license to the receptionist for copying)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone number: ( )
Occupation:	Employer/Address/City/Zip:		Employer phone number ( )
Primary insurance			❑ Medicaid ❑ Medicare ❑ Tricare ❑ Deductible ❑ Co-Pay
Subscriber's name:	Subscriber's SSN		Subscriber's Birth Date
Group number:	Policy number:	Co-payment: $	Deductable:$
Patient's relationship to subscriber: ❑ Self ❑Spouse ❑Child			
Secondary insurance (if applicable):			❑ Medicare ❑ Tricare ❑ Deductible ❑ Co-Pay
Subscriber's name:		Group number:	Policy number:

IN CASE OF EMERGENCY		
Name of friend or relative (not at same address):	Relationship	Home Phone ( ) Work Phone ( ) Cell Phone ( )
Address	City/Zip	Email Address:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Phoenix Healthcare Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date*