TAHOE FOREST
MULTISPECIALTY CLINICS

PATIENT REGISTRATION

PATIENT NAME_____ SSN_____DATE OF BIRTH _____GENDER_____

PHYSICAL ADDRESS _____CITY_____

MAILING ADDRESS_____CITY_____

STATE_____ZIPCODE_____COUNTRY_____

SCHOOL: _____ PREFERRED PHARMACY: _____ RELIGIOUS PREFERENCE:_____

FATHER'S NAME_____DOB _____SS# _____

HOME PHONE (_____)_____-_____ WORK PHONE (_____)_____-_____CELL PHONE (_____)_____-_____

ADDRESS_____EMAIL ADDRESS_____

EMPLOYER_____OCCUPATION_____

MOTHER'S NAME_____DOB _____SS# _____

HOME PHONE (_____)_____-_____ WORK PHONE (_____)_____-_____CELL PHONE (_____)_____-_____

ADDRESS_____EMAIL ADDRESS_____

EMPLOYER_____OCCUPATION_____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME_____COVERAGE EFFECTIVE DATE_____
MEMBER ID NUMBER_____GROUP NUMBER_____

ARE YOU THE SUBSCRIBER? ___YES____NO **If you are <u>not</u> the subscriber, please provide the following information*:***

SUBSCRIBER'S NAME_____ DATE OF BIRTH_____

SSN# _____ PHONE (_____)_____-_____

MAILING ADDRESS _____

PATIENT RELATIONSHIP TO SUBSCRIBER___SELF___SPOUSE___CHILD___OTHER

SECONDARY INSURANCE PLAN NAME_____COVERAGE EFFECTIVE DATE_____
MEMBER ID NUMBER_____GROUP NUMBER_____

ARE YOU THE SUBSCRIBER? ___YES____NO **If you are <u>not</u> the subscriber, please provide the following information*:***

SUBSCRIBER'S NAME_____ DATE OF BIRTH_____

SSN# _____ PHONE (_____)_____-_____

MAILING ADDRESS _____

PATIENT RELATIONSHIP TO SUBSCRIBER___SELF___SPOUSE___CHILD___OTHER

EMERGENCY CONTACT (NOT PARENT) _____PHONE (_____)_____-_____

ADDRESS_____RELATIONSHIP_____

WE REQUIRE THAT YOU PRESENT YOUR INSURANCE CARD(S) FOR PHOTOCOPYING. IF YOU DO NOT HAVE YOUR INSURANCE CARD(S) YOU WILL BE BILLED FOR ALL SERVICES PROVIDED UNTIL SUCH TIME AS WE RECEIVE A VALID INSURANCE CARD.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____DATE_____