

# Ravenwood HealthCare LLC

## REGISTRATION FORM

Today's Date:				PCP:	
<b>PATIENT INFORMATION</b>					
Patient's last name:		First:	Middle:	Marital status:	
Is this your legal name?	If not, what is your legal name?	Former name:		Birth date:	Age: Sex:
<input type="radio"/> Yes <input type="radio"/> No					<input type="radio"/> M <input type="radio"/> F
Address:					
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
Other family members seen here:					
<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:	
Is this person a patient here?	<input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance?		<input type="radio"/> Yes <input type="radio"/> No	
Occupation:	Employer:	Employer address:		Employer phone no.:	
Please indicate primary insurance:			Other:		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:			Other:		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:			Other:		
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative:		Relationship to patient:	Home phone no.:	Work phone no.:	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Ravenwood HealthCare LLC. I understand that I am financially responsible for any balance. I also authorize Ravenwood HealthCare LLC or insurance company to release any information required to process my claims.</p>					
Patient/Guardian signature				Date	