REGISTRATION FORM

SOUTH HAVEN FAMILY PHYSICIANS, P.C.

PATIENT'S NAME

PLEASE PRINT

Name ______________________________ ______________
Last First Middle Date

Address: ______________________________
City State Zip Code

Home Phone: ______________ Work Phone: ______________

Emergency Phone: ______________ Who's number is this ? ______________

Date of Birth: ______ Age: ______ SEX M ____ F ____ Social Security # ______________

Employer's Name: ______________ Occupation ______________

Status: Married ___ Single ___ Widowed ___ Divorced ___

REFEREED BY: ______________

RESPONSIBLE PERSON -- INFORMATION

PLEASE PRINT

Name ______________________________ ______________
Last First Middle Date

Address: ______________________________
City State Zip Code

Home Phone: ______________ Work Phone: ______________

Emergency Phone: ______________ Who's number is this ? ______________

Date of Birth: ______ Age: ______ SEX M ____ F ____ Social Security # ______________

Employer's Name: ______________ Occupation ______________

Status: Married ___ Single ___ Widowed ___ Divorced ___

PERSON WHO CARRIES - MEDICAL INSURANCE COVERAGE -- INFORMATION

PLEASE PRINT

Name ______________________________ ______________
Last First Middle Date

Address: ______________________________
City State Zip Code

Home Phone: ______________ Work Phone: ______________

Emergency Phone: ______________ Who's number is this ? ______________

Date of Birth: ______ Age: ______ SEX M ____ F ____ Social Security # ______________

Employer's Name: ______________ Occupation ______________

MEDICAL INSURANCE INFORMATION

Primary Insurance Company ______________

Address for Claim: ______________

Policy Holder's Name: ______________ Date of Birth: ______________

I.D. Number: ______________ Group Number: ______________

Is this Policy through your Employer ? Yes ____ NO ____

Does this Policy have Family / Dependent Coverage ? YES ____ NO ____

Secondary Insurance Company: ______________

Address for Claim: ______________

Policy Holder's Name: ______________ Date of Birth: ______________

I.D. Number: ______________ Group Number: ______________

Is this Policy through your Employer ? Yes ____ NO ____

Does this Policy have Family / Dependent Coverage ? YES ____ NO ____

Please Give Your Insurance Card to the Receptionist to Copy

****** PLEASE READ and SIGN the REVERSE SIDE of this FORM ******

Revised: Mar 2006