JELLISON INTEGRATIVE MD, LLC

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: __ Mr. __ Mrs. __ Miss __ Ms.	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ◯ M ◯ F

Address:		
Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

PHARMACY INFORMATION: Name: City/State: Phone:
Mail Order Pharmacy: Phone:

Chose clinic because/referred to clinic by:

Other family members seen here:

INSURANCE INFORMATION

(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? ◯ Yes ◯ No	Is this patient covered by insurance? ◯ Yes ◯ 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: __ 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 also authorize JELLISON INTEGRATIVE MD, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature Date