

Diabetes & Endocrine Associates, LLC REGISTRATION FORM

(Please Print)

Today's date:				Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security number:		Home telephone number: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer's telephone number: ()		
Referred to us by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Employer	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
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 telephone number: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer telephone number: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> BC/BS of Florida	<input type="checkbox"/> BC/BS Other	<input type="checkbox"/> AHC	
<input type="checkbox"/> UHC	<input type="checkbox"/> Champus	<input type="checkbox"/> McCreary	<input type="checkbox"/> Hospital Benefits		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. number:	Birth date: / /	Group number:	Policy number:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	Group number:	Policy number:
Name of secondary insurance (if applicable):			Subscriber's name:			Social Security Number:	Date of Birth:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home telephone: ()
			Work telephone: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Diabetes & Endocrine Associates, LLC to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>

6/28/05