Patient Registration Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

DOB: _____ SSN: _____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

If the Patient is a minor (under the age of 19), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____) _____

GUARANTOR (Person Responsible for Bill) ☐ CHECK BOX IF SAME AS ABOVE

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

DOB: _____ SSN: _____ Phone: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

AUTHORIZATION

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I have read and understand the Blue Lotus Primary Care Financial Policy. I also authorize payment of medical benefits paid directly to Blue Lotus Primary Care. I acknowledge that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Guardian Signature (If patient is a minor) Date