For Office Use Only	
Account #	
DX Code	

CENTER FOR FAMILY GUIDANCE, PC
PATIENT REGISTRATION FORM

Please Print Today's Date __/ /____

Patient Information

Patient's Last Name	First	Middle	☐ Mr, ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one)
					☐ Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name	Former Name	Birth Date	Age	Sex	
☐ Yes	☐ No					☐ M	☐ F

Street Address	City	State	Zip Code	Social Security Number	Home Phone

PO Box	City	State	Zip Code

Occupation	Employer	Employer Number

Referral Source (please check one box)	☐ Family ☐ Friend ☐ Close to Work/Home ☐ Yellow Pages ☐ Dr. ☐ Other

Cell Phone		Email Address	

Pharmacy Information

Pharmacy Name	Pharmacy Address	Pharmacy Phone Number	Pharmacy Fax Number

Insurance Information (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Guarantor (Person filling out paperwork)	Date of Birth	Address (if different)	Home Phone
Guarantor S.S. #			

Occupation	Employer	Employer Address	Employer Phone

Is this patient covered by insurance?	☐ Yes	☐ No	

Please indicate primary insurance	

Subscriber's Name (Person responsible for payment)	Subscriber's S.S. #	Date of Birth	Group #	Policy #	Co-Pay
					$

Patient's Relationship to Subscriber	☐ Self	☐ Child	☐ Spouse	☐ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber	☐ Self	☐ Child	☐ Spouse	☐ Other

In Case of Emergency

Name of Local Friend or Relative	Relationship to Patient	Home Phone	Work Phone

The above information is true to the best of my knowledge. I authorize Center for Family Guidance to release any information necessary to process claims for payment. I understand that my co-payment is due at the time of my appointment. I understand that I am responsible for the fees for the services provided and should my account become delinquent, I am responsible for any attorney or collections fees incurred due to collecting a debt.

- Failure to cancel an appointment 48 hours in advance may result in a fee. Please initial. _____

X	
Patient/Guardian Signature	Date