Incredible Health, LLC.

REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient name:				Date of Birth:	
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Email Address		
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable): [Secondary Insurance]		Subscriber's name: [Name]		Group no.: [Group #]	Policy no.: [Policy #]
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
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 authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.					
Patient/Guardian signature			Date		