**Faith Home Care Practitioners**
34 NE Boistfort St. Ste. 123, Chehalis, WA 98532
360-996-4443 (Office) ● 855-619-1638 (Fax) ● www.faithhcp.com

# PATIENT REGISTRATION FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## 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? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

How did you hear about us? (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Website ❑ Facility ❑ Other Who? _____

Other family members seen by us:

## 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

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

| Please indicate primary insurance | | | | | |
|---|---|---|---|---|---|
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Policy no.: | Group no.: | Co-payment: $ |

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Policy no.: | Group 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 authorize my insurance benefits be paid directly to my provider. I understand that I am financially responsible for any balance. I also authorize Faith Home Care Practitioners, PLLC or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*