REGISTRATION FORM

CHART # _____

Have you or any member of your family ever received treatment at this office? ☐ Yes ☐ No

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	BIRTHDATE	SOCIAL SECURITY #	INSURANCE
Head of Household						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

ADDRESS	CITY	STATE	ZIP	TELEPHONE

EMPLOYMENT	CITY	STATE	ZIP	TELEPHONE
Head of Household				
Spouse				

Indicate if a person living outside your household is responsible for payment:

NAME	ADDRESS	TELEPHONE

Person to contact in case of an emergency: _____

Relationship to self: _____ Telephone: _____

***** PRESENT ALL INSURANCE CARDS TO RECEPTIONIST *****

As indicated by my signature below, I have completed this form fully and completely certify that I am the patient or fully authorized general agent of the patient. I authorize the release of any medical information necessary to furnish the information necessary to process all insurance claims and request payments of benefits to Cornerstone Family Health for all services rendered.

_____ _____

Signature *Date*