CLINIC BY THE SEA
REGISTRATION FORM

Todays Date:			PCP:	
PATIENT INFORMATION				
Name Last: First: Middle:			Previous Name:	Marital status: Single / Married / Divorced / Separated / Widowed / Partner
Race/Ethnicity:	Social Security No.:	Date of Birth:	Age:	Sex: Male Female
Cell Phone #:		Home Phone #:		
Mailing Address:				
City:	State:	Zip Code:	Email address:	
Who referred you to us?				
Names of your specialist doctors you see:				

INSURANCE INFORMATION	
(Please give your insurance card(s) to the receptionist)	
Primary Insurance:	
Secondary Insurance:	
PHARMACY	
Pharmacy Name:	Location:
Mail-order Pharmacy:	

IN CASE OF EMERGENCY		
Name of local friend/relative (not living at the same address):	Relationship to patient:	Cell phone #:

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 Clinic by the Sea or insurance company to release any information required to process my claims. By signing below, I, the undersigned, patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including land and radiographic studies, as ordered, by this office and its health care providers.

_____ _____

Patient/Guardian Signature Date