LONGSTREETCLINIC
Your Health. Our Specialty.

Patient Registration Form

Date:_____ How did you hear about TLC? _____

INFORMATION ON THE PERSON BEING SEEN TODAY

Patient's Name

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Emergency Phone: _____ Emergency Contact (Relationship): _____

Date of Birth: _____ / _____ / _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Unknown

Social Security Number: _____ - _____ - _____ Email: _____

Employer Name: _____ Employer Phone: _____

Race:	**Ethnicity:**
____White/Caucasian	____Non-Hispanic/Non-Latino
____Black/African American	____Hispanic/Latino
____Asian	____Unknown
____Other (explain)_____	____Declined
____Declined	

Preferred Language:_____English ____Spanish ____Other_____

Preferred Method of Communication

❑ Letter Phone Number: _____ Email Address: _____

INFORMATION ON THE PERSON RESPONSIBLE FOR PATIENT

Responsible Person's Name

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Emergency Phone: _____ Emergency Contact (Relationship): _____

Date of Birth: _____ / _____ / _____ Gender: ❑ Male ❑ Female

Social Security Number: _____ - _____ - _____ Email: _____

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INSURANCE INFORMATION:

***** Please allow the receptionist to make copies of your insurance cards*****

PLEASE NOTE: It is the policy of ***Longstreet Clinic*** that we collect full payment at the time of your visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. Please understand that if you are not with a ***contracted*** carrier, you must pay for your visit at time of service. If you have a concern about your ability to pay for the services in full, please speak with the receptionist at time of service.

PRIMARY INSURANCE CARRIER: _____

Name of Policyholder:_____ Policyholder's DOB: ___/___/___

Policyholder's Employer: _____ Policyholder's SS#: _____

Policyholder's Relationship to patient: _____

SECONDARY INSURANCE CARRIER: _____

Name of Policyholder:_____ Policyholder's DOB: ___/___/___

Policyholder's Employer: _____ Policyholder's SS#: _____

Policyholder's Relationship to patient: _____

I authorize *Longstreet Clinic* to release to my insurance company any information required for services provided. I authorize payment of Medical Benefits to *Longstreet Clinic.*

Signature: _____

I understand that I remain responsible to *Longstreet Clinic* for any and all charges.

Signature: _____