The Longstreet Clinic, P.C.
Doctors You Know. Care You Trust.

Patient Registration Form

Date: _____ How did you hear about TLC? _____

INFORMATION ON THE PERSON BEING SEEN TODAY

Patient's Name (First, Middle Initial, Last)

_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Emergency Phone: _____ Emergency contact (Relationship)_____

Date of Birth: ____/____/_____ Sex: Male _____ Female _____

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

Social Security Number: _____ **E-mail:** _____

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:_____ E-mail address:_____

INFORMATION ON THE PERSON RESPONSIBLE FOR PATIENT

Responsible Person's Name (First, Middle Initial, Last):

_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Emergency Phone: _____ Emergency contact (Relationship):_____

Date of Birth: ____/____/____ Sex: Male _____ Female _____

Social Security Number: **E-mail:**

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INSURANCE INFORMATION:

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

PLEASE NOTE: It is the policy of ***The 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 *The Longstreet Clinic, P.C* . to release to my insurance company any information required for services provided. I authorize payment of Medical Benefits to *The Longstreet Clinic, P.C.*

Signature: _____

I understand that I remain responsible to *The Longstreet Clinic, P.C* . for any and all charges.

Signature: _____