**Living Healthy**

**REGISTRATION FORM**

(Please Print)

|  |
| --- |
|  |

City:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Today’s date: | PCP: | | | |
| **PATIENT INFORMATION** | | | | |
| Last name: First | | | Birth date  / / | |
| Street address: | | | Home phone no.:  ( ) | |
|  | | State: | | ZIP Code: |

**INSURANCE INFORMATION**

(Please bring your insurance card and photo ID.)

|  |  |  |  |
| --- | --- | --- | --- |
| 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.:  ( ) |

Is this patient

covered by insurance?\_□\_Yes □ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate primary insurance

Subscriber’s name: Policy no.: Group no.:

Patient’s relationship to subscriber:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |

Patient’s relationship to subscriber:

|  |  |  |  |
| --- | --- | --- | --- |
| **IN CASE OF EMERGENCY** | | | |
| Name: | 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 the physician. I understand that I am financially responsible for any balance. I also authorize HEPSA Living Healthy or insurance company to release any information required to process my claims.

*Patient/Guardian signature Date*