

Heidi Freeman, M.D.
REGISTRATION FORM

(Please Print)

Today's date:				Primary Care Physician:				
PATIENT INFORMATION								
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Married / Other
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			Maiden name:		Birth date: / /	Age:	
Street address:			Social Security no.:			Home phone no.:		()
or P.O. box:		City:	State:		ZIP Code:	Cell phone no.:		()
Occupation:	Employer:		Employer address:			Employer phone no.:		()
Chose clinic because/Referred to clinic by (please check one):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Is it okay to contact you by email for non-emergency reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No				Email address:				

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Name of policyholder:		Policyholder's S.S. no.:		Birth date: / /			
Occupation:	Employer:	Employer address:			Employer phone no.:		()
Primary insurance		Group no:		Policy no:		Co-payment: \$	
Patient's relationship to policyholder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Policyholder's name:			Group no.:	Policy no.:	
Patient's relationship to policyholder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative :		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 Heidi Freeman, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

