Brighton Family Medicine, LLP
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	□ Mr. □ Mrs.	□ Miss □ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? □ Yes □ No	If not, what is your legal name?	If child – Mother's Maiden Name	DOB: / /	Age:	Sex: □ M □ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred by (please check one box):	□ Friend:	□ Insurance Plan	□ Hospital

□ Family	□ Dr.	□ Close to home/work	□ Yellow Pages	Other:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? □ Yes □ No Driver's License #/State

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? □ Yes □ No

Please indicate primary insurance	□ Blue Choice	□ BCBS :	□ Preferred Care	□ Aetna	□ UHC

□ BC Option	□ CHPS	□ PC Option	□ Medicare	□ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	□ Self	□ Spouse	□ Child	□ Other

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

Patient's relationship to subscriber:	□ Self	□ Spouse	□ Child	□ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	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 Brighton Family Medicine or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*