The DeWitt Clinic, PA

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?	If not, what is your legal name?	Driver's License #:	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

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

City:	State:	Zip Code:	Cell Phone:

Occupation:	Employer:	Employer phone no.:
		( )

Email Address:	Name of Family Doctor you have seen in the past?	
Referred by (please check one box): ❑ Dr.❑ Insurance Plan❑ Hospital	When did you seen him/her last?	

Other family members seen here:

Spouse: Date of Birth: Employer: Work #:

PHARMACY INFORMATION

Name of Pharmacy:		Address and City:	Phone#:

PATIENT PORTAL

Do you want to sign up for the patient portal? (patient portal is to access your appointments, some medical records and prescription information	YES NO (Please circle one)	Please provide email if you answered yes: _____

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ BCBS	❑ Humana Military	❑ Texan Plus	❑ Texas HealthSpring
❑ Aetna	❑ United Health Care	❑ Medicare Replacement	❑ Medicaid	❑ Other	

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

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 acknowledge that I am responsible to provide current and accurate insurance information to The DeWitt Clinic, in the event that my insurance company denies or does not pay my bill in a reasonable time frame, I will be solely responsible for the balance in full. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any copays, deductibles or balance not allowed by my insurance company. I also authorize The DeWitt Clinic, PA or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*