PERRY MEDICAL CLINIC
401 Northwood Drive, Centre, AL 35960

PATIENT REGISTRATION FORM
Date: _____

PATIENT INFORMATION

Patient's Last Name: First: Middle: (preferred/Nickname)		Marital Status (Circle One) Single / Mar / Div / Sep / Widow		
Spouse/Parent Name:	Social Security Number:	Birth Date: / /	Age:	Gender: ❑ M ❑ F
Home Address:	City/State/Zip	Home Phone: ( ) Cell Phone: ( )		
Employer Name and Address:	City/State/ZIP	Work Phone ( )		
Email:	Preferred Pharmacy	Pharmacy Phone: ( )		

RESPONSIBLE PARTY

Name:	Social Security # Date Of Birth / /
Address:	Home Phone ( ) Cell Phone ( )

ILLNESS / ACCIDENT / INJURY INFORMATION

If accident/ injury, how did it happen:		Onset symptom/ accident date: Date Last Worked:
Is this a Workman's Compensation Case? ❑ Yes ❑ No	If Yes, please complete the following:	
Employer Name / Location:	WC Claim # / Approved By:	Employer Phone No.:
WC Insurance Carrier Name:	Insurance Address:	( ) Insurance Phone No.:

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name:	Policy Holder Name:	Contract No.:
Patient's Relationship To Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other	Policy Holder Birth Date: / /	Policy Holder SSN:
Group No.:	Co-Payment: $	Employer Phone No: ( )
Employer Name:		

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name:	Policy Holder Name:	Member/Policy/Contract No.:
Patient's Relationship To Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other	Policy Holder Birth Date: / /	Policy Holder SSN:
Group No.:	Co-Payment: $	Employer Phone No.: ( )
Employer Name:		

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 due. I will be financially responsible for any collection balance or fees required to collect any outstanding balance. I also authorize Perry Medical Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ *Date* _____