South Shore Family Medical Associates, P.C.
DR. ALLAN S. DETWEILER

PATIENT REGISTRATION FORM

Patient Account #

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI: ____

Address: _____ City: _____ State: ____ Zip: _____

Social Security #: ____-____-____ Date of Birth:____/____/____ Age: _____

Title: Dr, Mr, Mrs, Miss, Ms (circle one) Marital Status: M W S D (circle one)

Sex: M F (circle one) Race: _____ Occupation: _____

Referring Physician: _____

TELEPHONE NUMBERS

Home: (____)_____-_____ Work: (____)_____-_____ ext._____

Emergency Contact: _____ Phone: (____)_____-_____ ext._____
Relation to Patient: _____

INSURANCE INFORMATION

(PLEASE ATTACH A COPY OF THE FRONT & BACK OF PATIENT'S INSURANCE CARD FOR OUR RECORDS)

Type of Insurance: (check one) ❑ Medicare ❑ Medicaid/ State Program ❑ Commercial ❑ Blue Cross/ Blue Shield ❑ HMO / PPO

Primary Insurance		Secondary Insurance	
Insurance Company Name		Insurance Company Name	
Address (city, state, zip)		Address (city, state, zip)	
Insured's Name		Insured's Name	
SS#:	Patient Relation (check one) ❑ self ❑ spouse ❑ dependent	SS#:	Patient Relation (check one) ❑ self ❑ spouse ❑ dependent
Policy / Identification #	Group/Plan #	Policy / Identification #	Group/Plan #

Employer's Name, Address, Phone #:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR PROVIDER OF SERVICES.

_____ **PATIENT'S SIGNATURE**

_____ **DATE**