REGISTRATION RECORD

1. How did you hear about PARK HEALTH CENTER?

_____

2. Who referred you to PARK HEALTH CENTER?

_____

Personal Information:

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip_____

Home Phone: ( ) _____ Work Phone: ( ) _____

E-mail _____ Cell Phone: ( ) _____

Date of Birth _____/_____/_____ Male: _____ Female: _____

Social Security _____

Marriage Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed ____

Father: _____ Mother _____

Signature: _____

INSURANCE INFORMATION:

Insurance Co: _____ Card Holder: _____

ID # : _____ Group # : _____

EMERGENCY INFORMATION:

Emergency Contact: _____ Relationship: _____

Day Phone: ( ) _____ Evening Phone: ( ) _____

I request that payment of authorized Medical Benefits be made on my behalf directly to the medical provider(s) I authorize any holder of medical information about me to be released to my insurance company and its agents to determine these benefits. I will be responsible for any deductibles, co-payments, or balances not paid for by my insurance company(s).