Rosewood Health Care
Registration Form
(Please Print)

Patient Information

Patient's Last Name:	First:	Middle:	Mr. Miss Mrs. Ms.	Marital Status (circle one) Single/ Mar/ Div/ Sep /Wid
Is this your legal name? Yes No	If not, what is your legal name?		Date of Birth:	Age: Sex: M F
Home Phone ( ) -	Is it okay to leave a detailed message? Yes No	Cell Phone ( ) -		Is it okay to leave a detailed message? Yes No
Mailing Address:				Social Security #
Permanent Address:		City:	State:	Zip Code:
Email Address:		Employer:		Employer Phone:
Chose clinic because/ referred to clinic by (please check one box): Dr. Insurance Plan Hospital Family Location Yellow Pages Other				
Other family members seen here:				

Insurance Information
(Please give your card to the receptionist.)

Person responsible for bill:	Their Date of Birth:	Address(if different):	Home Phone ( ) -
Relation to you? Spouse Parent/Guardian Other please specify		Is this person a patient here? Yes No	
Occupation:	Employer:	Employer Address:	Employer Phone ( ) -
Is this patient covered by insurance? Yes No If no then when will they be covered?			

Name Of Insurance:	ID Number:	Group Number:	Co-Payment: $
Name on the Card(subscriber):	Birth Date:	Your relationship to subscriber: Self Spouse Child Other	
Secondary Insurance(if applicable):	ID Number:	Group Number:	Co-Payment: $
Name on the Card(subscriber):	Birth Date:	Your relationship to subscriber: Self Spouse Child Other	

In Case of Emergency

Name:	Relationship to patient:	Phone ( ) -	Is it okay to leave a detailed message? Yes No

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rosewood Health Care or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:	If Guardian Print Name:	Date: