DATE_____

MCKINLEY MEDICAL CLINIC
PATIENT REGISTRATION

PCP: _____

PATIENT INFORMATION

LAST NAME: _____
FIRST NAME: _____ MIDDLE INITIAL _____
ADDRESS: _____
CITY, STATE: _____
ZIP: _____
EMPLOYER: _____
EMPLOYER ADDRESS: _____
CITY, STATE: _____
ZIP: _____
HOW WERE YOU REFERRED TO OUR OFFICE:
_____

HOME PHONE(_____) _____
WORK PHONE (_____)_____
DATE OF BIRTH _____
(CHECK ONE) __ EMPLOYED __RETIRED __FULL TIME STUDENT
__OTHER_____
SOCIAL SECURITY #: _____
MARITAL STATUS: ____M ____S ____D SEX: ____M ____F
NUMBER OF DEPENDENTS: _____ RACE: _____
PREFERRED LANGUAGE: ____ENGLISH ____ SPANISH

MEDICAL INSURANCE: ____YES ____NO

SPOUSE / RESPONSIBLE PARTY INFORMATION

NAME: _____
ADDRESS: _____
CITY, STATE: _____ZIP: _____
WORK / DAY PHONE (_____) _____

RELATIONSHIP: _____D.O.B._____
EMPLOYER: _____
ADDRESS: _____
SOCIAL SECURITY NUMBER:_____

EMERGENCY CONTACT

NAME: _____
ADDRESS: _____
CITY, STATE: _____ZIP: _____

RELATIONSHIP: _____D.O.B. _____
BEST PHONE NUMBER (_____) _____
ALTERNATE PHONE NUMBER (_____)_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

___COMMERCIAL ___MEDICAID ___MEDICARE ___WORKER'S COMPENSATION ___OTHER_____

CARRIER NAME_____ SUBSCRIBER #_____
INSURE / CARD HOLDER'S NAME_____ GROUP #_____
RELATIONSHIP_____ D.O.B._____ SSN_____
PHONE NUMBER (_____)_____

SECONDARY INSURANCE INFORMATION

___COMMERCIAL ___MEDICAID ___MEDICARE ___WORKER'S COMPENSATION ___OTHER_____
CARRIER NAME_____ SUBSCRIBER #_____
INSURE / CARD HOLDER'S NAME_____ GROUP #_____
RELATIONSHIP_____ D.O.B._____ SSN_____
PHONE NUMBER (_____)_____

WORKER'S COMPENSTION INFORMATION

COMPANY NAME_____ COMPANY PHONE (_____)_____
SUPERVISOR'S NAME_____ SUPERVISOR'S PHONE (_____)_____

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. I also authorize McKinley Medical Clinic or my insurance companies to release any information required to process my claims.	_____ ***Patient / Guardian signature*** _____ ***Date***