UNIVERSITY SPECIALTY CLINICS
Patient Registration

Date:_____

PATIENT INFORMATION

Patient Name: _____ Sex: M F Race: _____ DOB: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____ County:_____

Home phone#: _____ Work phone #: _____ Cell Phone #:_____

Social Security #: _____ Marital Status: _____ Email Address:_____

Primary Care Physician:_____

Employer Name/Address: _____

EMERGENCY CONTACT ***(* Not your home phone please)***

Name: _____ Phone#: _____ Relationship: _____

PERSON RESPONSIBLE FOR PAYING (IF DIFFERENT FROM PATIENT)
Or Subscriber for primary insurance

Responsible Person's Name:_____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home phone#: _____ Work phone #: _____ DOB:_____/_____/_____

Social Security #: _____

Employer Name and Address:

_____

_____

INSURANCE INFORMATION

1. INSURANCE COMPANY: _____ Phone#: _____ Employer_____

Mailing Address: _____ _____

Policy#_____ Group#_____ Subscriber's Name_____

Subscriber's Birth Date_____ Subscriber's SS #_____Relationship to patient_____

2. INSURANCE COMPANY: _____ Phone#: _____ _ Employer_____ _____

Mailing Address: _____

Policy#_____ Group#_____ Subscriber's Name:_____

Subscriber's Birth Date_____ Subscriber's SS #_____ Relationship to patient _____

_____

Patient Signature Date