

**PHS-CLINIC
EXPANSION
REGISTRATION**
(Please Print)

Today's date:			Current PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()	
Eligibility for Expansion <input type="checkbox"/> Employee <input type="checkbox"/> Employee Family <input type="checkbox"/> Native American Spouse/Family			Tribal I.D. _____			
Other family members seen here:						

INSURANCE INFORMATION						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance _____						
Please indicate secondary insurance _____						
Medicaid indicate I.D. number _____						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Network Provider _____						