

**DANIEL ISLAND FAMILY CARE
Melissa H. Hunter, MD
REGISTRATION FORM**

IF THIS FORM IS NOT FILLED OUT COMPLETELY WE WILL NO LONGER FILE INSURANCE (Please Print)

Today's Date:		PCP: MELISSA HUNTER				
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: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
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.: ()	
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Email Address:						

IF THIS PORTION OF THE FORM IS NOT FILLED OUT ENTIRELY WE WILL NO LONGER FILE YOUR INSURANCE FOR YOU. THANK YOU

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
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		<input type="checkbox"/> BCBS (ANY KIND)	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> UNITED HC	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CIGNA
<input type="checkbox"/> AETNA	<input type="checkbox"/> MEDCOST	<input type="checkbox"/>	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other	
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	

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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 DANIEL ISLAND FAMILY CARE or insurance company to release any information required to process my claims.				
Patient/Guardian signature			Date	