Londonderry Nurse Practitioners
Whole Health Consultants

REGISTRATION FORM

Today's Date:				PCP:		
PATIENT INFORMATION						
Patient's last name:	First:	Middle:		Marital status:		
Is this your legal name?	If not, what is your legal name?	Former name:		Birth date:	Age:	Sex:
○ Yes ○ No						○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]						
Social Security no.:	Home phone no.:			Cell phone no.:		
Occupation:	Employer:			Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option): ○ Doctor's name:						
○ Because:						
Other family members seen here:						
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?	○ Yes ○ No	Is this patient covered by insurance?		○ Yes ○ No		
Occupation:	Employer:	Employer address:		Employer phone no.:		
Please indicate primary insurance:						
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:	
Patient's relationship to subscriber:						
Name of secondary insurance (if applicable):	Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:						
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 [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date