Mill Creek Family Practice
Registration Form

Today's date:	PCP:

Patient Information

Patient's last name: First: Middle:	□ Mr. □ Mrs.	□ Miss □ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Best Phone No: Is it okay to send you a text message? □ Yes □ No	Birthdate: / /	Age:	Sex: □ M □ F

Street Address:	Social Security No:

City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone No:

Email Address:	Would you like to sign up for our Patient Portal? An email invitation will be sent to you. □ Yes □ No

Pharmacy:	Pharmacy Phone No:

Ethnicity (please circle one):
Not Hispanic or Latino African American Hispanic Asian Caucasian Other

Insurance Information

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birthdate: / /	Address (if different):	Best Phone no:

Is this person a patient in our office? □ Yes □ No

Occupation:	Employer:	Employer Phone No:

Is this patient covered by insurance? □ Yes □ No

Subscriber's Name:	Subscriber's SS No:	Birthdate: / /	Group No:	Policy No:	Co-payment: $

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No:	Policy No:

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

In Case of Emergency

Name of friend or relative:	Relationship to Patient:	Best 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 provider. I understand that I am financially responsible for any balance. I also authorize Mill Creek Family Practice or insurance company to release any information required to process my claims.

_____ _____

Parent/Guardian Signature Date