FULLY ARMORED FAMILY HEALTH AND FITNESS
REGISTRATION FORM

Today's Date:			PCP If other Than Alta Skelton, NP:		
PATIENT INFORMATION					
Patient's last name: First:		Middle [Choose an item]	Marital status: [Choose an item]		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:					
Social Security no.:	Home phone no.: Email: May we contact you by email? Phone number that it ok to leave message on		Cell phone no.: May we Text or use your cell phone to contact you?		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by: ○ ○ Other					
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.: May we call you at work?		
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: [Choose an item] | Other: [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 FULLY ARMORED FAMILY HEALTH AND FITNESS or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date