Allen Stark MD **Please Circle One** **Carol Stark MD**

REGISTRATION FORM

ALL AREAS MUST BE COMPLETED **Mark One Area** **New Patient _____** **Update Only _____**

Front and Back MUST BE SIGNED

Primary Care Physician:	PCP Phone # __ __ __ - __ __ __ - __ __ __ __
	PCP Fax # __ __ __ - __ __ __ - __ __ __ __

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Home phone number: __ __ __ - __ __ __ - __ __ __ __		Cell phone number: __ __ __ - __ __ __ - __ __ __ __	
P.O. box:	City:	State:	ZIP Code:		
Occupation: Reason for Visit:	Employer:	Employer phone no.: __ __ __ - __ __ __ - __ __ __ __			
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					
Occupation:	Employer:	Employer address:	Employer phone no.: __ __ __ - __ __ __ - __ __ __ __		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	Phone # __ __ __ - __ __ __ - __ __ __ __	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	Phone # __ __ __ - __ __ __ - __ __ __ __	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell 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 Allen Stark MD and/or Carol Stark MD or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*