Bey Health Solutions LLC
REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle: [Initial]	Marital status:	

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Date of Birth:	Age:	Sex: ☐ M ☐ F

Address: [Address/ P.O Box, City, ST ZIP Code]		
Social Security no.: [SS#]	Home phone no.: [Phone]	Cell phone no.: [Phone]
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option): ☐ Doctor(list name)

☐ Word of mouth ( ) internet ( ) google search () Ads

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different from above):	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): [Friend or relative name]	Relationship to patient: [Relationship]	Home phone no.: [Phone]	Work phone no.: [Phone]

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 [Bey health Solutions LLC] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date