ROCHESTER INTERNISTS, PLLC
Registration Form
(Please Print)

Patient's Last Name:_____ **First:**_____

Is this your legal name: O YES O NO If not, what is your legal name:_____

Date of birth____/____/____ Sex: O Female O Male SSN:_____-_____-_____

Marital status (circle one): single / married / divorced / separated / Widowed

Address: City:

State: Zip Code: Primary Phone: Secondary Phone:

Email:_____

Race: OAsian OWhite OBlack/African American OOther O Decline **Ethnicity:** O Hispanic/Latino O other O Decline

INSURANCE INFORMATION
(Please give Insurance Cards to Receptionist)

Primary Insurance:	Subscriber's Name:
Policy Number:	Group # :
Subscriber's SSN:	Birth Date:

Patient's relationship to subscriber: O Self O Spouse O Child O Other

Secondary Insurance:	Subscriber's Name:
Policy Number:	Group # :
Subscriber's SSN:	Birth Date:

Patient's relationship to subscriber: O Self O Spouse O Child O Other

Person Responsible for bill:	Address(if different):
Date of Birth:	Phone number:

IN CASE OF EMERGENCY

NAME:	Relationship:	Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rochester Internists or insurance company to release any information required to process my claims.

Patient/Guardian Signature **Date**