Desire Healthcare LLC
Phone: **(301) 494-4060**
Fax: **(301) 494-4055**
Email: **Info@desirehealthcarellc.com**

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last name: Middle Initial:	First Name:	Marital status:		
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth Date:	Age:	Sex: ◯ M ◯ F

Other family members seen here:

Social Security #:	Home Phone #:	Cell Phone #:
Occupation:	Employer:	Employer Phone #:

Address: [Address/P.O Box, City, ST, ZIP Code]

Race: American Indian or Alaskan Native Asian, Native Hawaiian, or other Pacific Islander Black or African American, White, Hispanic, other race, other Pacific Islander, Unreported/refuse to report

Primary Language:

Ethnicity: Hispanic, Non-Hispanic, Refuse to report

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth Date:	Address (if different from Patient's):	Home Phone 3:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	
Occupation:	Employer:	Employer Address:	Employer Phone #:

Please indicate primary insurance: Other: [Other insurance]:

Subscriber's name:	Subscriber's SSN:	Birth Date:	Group #:	Policy #:	Co-payment $:

Patient's relationship to subscriber: Other: [Relationship to subscriber]

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: Other: [Relationship to subscriber]:

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	Relationship to Patient:	Cell Phone #:	Work phone #:

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 Desire Healthcare LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature　　　　　　　　　　　　Date