Center for Endocrine Health (P.C)   Registration Form

Patient First Name :____________________Middle Initial ___Last Name:____________________________

Address:______________________________City:_______________________State:_______Zip:__________

DOB:___________________________________SSN:____

Home Phone:__________________Work Phone:__________________Cell Phone:_______________________

Email:____________________________ Preferred contact method:__________________________________

Marital Status :____________________________Employer:____

Race:_____________________________________Ethnicity:_______________________________________

Emergency Contact Name:______________________Relationship _________________Ph:_______________

Preferred Pharmacy:____

Insurance Information (all fields required)

Primary Insurance Name:____

Policy Holder Name:_________________________SSN:______________________DOB:_________________

Policy Holder Employer:____

ID #_________________________________Group/policy#____

Secondary Insurance Name:____

Policy Holder Name:________________________________SSN:___________________DOB:____________

Policy Holder Employer:____

ID #_________________________________Group/policy#____

Referring Physician Information

Referring Physician First Name:________________________________Last Name:________________________

- **We bill your insurance company as a courtesy to you. It is your responsibility to know your benefits including deductibles, co-insurance and co-pays. Ultimately, you are responsible for payment if service is not covered. Please be prepared to make a payment or co-payment at the time of service. Thank you.**